

Lakewood Rest Home Limited - Lakewood Rest Home

Introduction

This report records the results of a Certification 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: Lakewood Rest Home Limited

Premises audited: Lakewood Rest Home

Services audited: Dementia care

Dates of audit: Start date: 30 October 2019 End date: 31 October 2019

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: 32

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Lakewood rest home is owned and managed by a non-clinical owner/manager. The home provides dementia level care for up to 36 residents. On the day of audit there were 32 residents in total.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files; observations and interviews with residents, relatives, staff, management and general practitioner.

The manager has owned Lakewood for the past 14 years but has only recently taken over the manager's role. She is supported in the role by a service supervisor who is an experienced healthcare assistant and an experienced registered nurse who has been in the role since 2017.

The service has a business plan, quality process, staff orientation and in-service training programme documented.

Improvements are required around; Informed consent, implementation of the quality process, staff training, care plan documentation 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.		Some standards applicable to this service partially attained and of low risk.
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Lakewood Rest Home endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers' rights is provided to families. Cultural diversity is inherent and celebrated. There is documented evidence that family are kept informed. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. The owner/manager and supervisor and RNs are responsible for the day-to-day operations of the facility. Goals are documented for the service with evidence of annual reviews. Quality and risk management programmes are in place, which includes managing adverse events and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided across seven days a week.

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 low risk.
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The service provides an information booklet for residents/families which includes specific information relating to a secure environment. 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.

Medication policies reflect legislative requirements and guidelines. Registered nurses and Healthcare assistants are responsible for administration of medicines. The electronic medicine charts reviewed met prescribing requirements and were reviewed at least three monthly by the general practitioner.

A diversional therapist coordinates and implements the activity programme with the support of care staff. The activity programme includes meaningful activities that meet the recreational needs and preferences of each resident. Individual 24-hour activity plans are developed in consultation with resident/family. There are regular outings into the community.

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 of the menus. All staff are trained in food safety.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current building warrant of fitness. There is a reactive and planned maintenance schedule. Residents' rooms, lounge areas and environment are suitable for residents requiring secure dementia care. Outdoor areas are safe and secure and accessible for the residents. There is adequate equipment for the safe delivery of care. The building and equipment are well maintained. All chemicals are stored safely. There is a mix of rooms with shared ensuites and communal toilets and showers. The staff maintain a tidy, clean environment. All laundry is completed on site. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. Staff receive training in emergency procedures.

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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Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had one resident using restraint and no enablers. Assessments, monitoring charts and a restraint register are in place. Evaluations are completed individually and at restraint meetings.

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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (registered nurse) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a range of policies, standards and guidelines around infection control. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and resources 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.

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	45	0	4	1	0	0
Criteria	0	96	0	4	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, and as part of the ongoing training programme (June 2019). Interviews with staff (five healthcare assistants, two registered nurses, the owner/manager, supervisor and the diversional therapist), reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	PA Low	<p>There are established informed consent policies/procedures. All six files reviewed (including one resident under a compulsory treatment order – CTO) included signed informed consent forms and advanced directive instructions. Interviews with healthcare assistants and relatives identified that consents are sought in the delivery of personal cares.</p> <p>Five of five long-term residents had activated enduring powers of attorney (EPOA) in place. There was no EPOA for the resident under CTO for a period of three months. Then a review of the CTO is required.</p> <p>Resuscitation forms for the six resident files were reviewed and found to be inappropriately signed.</p> <p>Admission agreements were signed by the resident or nominated representative. Discussion with relatives</p>

		identified that the service actively involves them in decisions that affect their relative's lives.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services as part of code of Rights training (June 2019).
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events. The service provides assistance to ensure that the residents are able to participate in as much as they desire and can safely do. Family meetings are held quarterly.
<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 on entry to the service. The service maintains a record of all complaints, both verbal and written, by using a complaint register. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner.</p> <p>Discussions with relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. The two complaints received in 2019 were reviewed with evidence of appropriate follow-up actions taken.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Details relating to the Code are included in the resident information pack that is provided to family. This information is also available at the entrance to the facility. The registered nurses discuss aspects of the Code with family on admission.</p> <p>All six family members interviewed, reported that the residents' rights are being upheld by the service.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. The March privacy internal audit scored 100% and training was provided to staff in October 2019 around privacy and respect. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were no residents who identified as Māori on the day of audit.</p> <p>Māori consultation is available through Māori staff who are employed by the service. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All healthcare assistants interviewed were aware of the importance of whānau in the delivery of care for Māori residents.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.</p> <p>All care plans reviewed included the resident's social, spiritual, cultural and recreational needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with healthcare assistants confirmed their understanding of professional boundaries, including the boundaries of the healthcare assistant's role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is an infringement with the person concerned.</p>

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Lakewood has a documented quality and risk programme developed by an external consultant (link 1.2.3.6). There are up-to-date policies and procedures also developed by an external consultant. The service has implemented an electronic medication system.</p> <p>Registered nursing staff are rostered on duty available seven days a week. Two general practitioners (GPs) visit the facility two days a week. The GP reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. Physiotherapy services are provided on site as required.</p> <p>Registered nurses interviewed described access to training and a supportive management team. Competencies are completed for key nursing skills.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs.</p> <p>Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident's file. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Ten accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</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>	FA	<p>Lakewood rest home is owned and managed by a non-clinical owner/manager. The home provides dementia level care for up to 36 residents. On the day of audit there were 32 residents in total, including one resident under a compulsory treatment order – (CTO). The manager has owned Lakewood for the past 14 years, but has only recently taken over the manager's role, having worked in an administration role for the service. She is supported in the role by a service supervisor who is an experienced healthcare assistant and an experienced registered nurse who has been in the role since 2017. Two further registered nurses complete the clinical leadership team.</p>

		<p>A vision, mission statement and objectives are in place. There is a documented business plan, nursing objectives and risk plan documented, which were reviewed May 2019. The quality process has been developed by an external consultant and personalised to the service.</p> <p>The lead registered nurse has maintained over eight hours annually of professional development activities related to managing an aged care service. The manager is new to the role.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>The supervisor who is employed full time, supports the owner/manager, and steps in when the owner manager is absent. A lead registered nurse manages the clinical aspects of the service</p> <p>The service operational plans, policies and procedures promote a safe and therapeutic focus for residents affected by the aging process and promotes quality of life.</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>	PA Low	<p>A quality and risk management programme is documented. Interviews with the managers and staff reflected their understanding of the quality and risk management systems.</p> <p>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.</p> <p>Monthly staff/quality meetings have a set agenda that covers all aspects of the service quality meetings. Additional agenda items are documented as discussed as needed, including staff issues, feedback and as ad hoc training as needed. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, restraint use, pressure areas, wounds, and medication errors. Each month the lead RN reviews and collates the quality and risk data as well as infection control. A report is documented and an action plan. This report and action plan are not documented as reported to meetings or documented as followed up and signed off.</p> <p>An annual internal audit schedule was sighted for the service, but not all internal audits were documented as occurring as per the audit schedule.</p> <p>An annual satisfaction survey is completed with residents and relatives, with the 2019 survey currently in progress.</p>

		<p>Falls prevention strategies are in place. A health and safety system is in place. There are health and safety policies and procedures documented. The service has recently commenced health and safety meetings separately from the staff/quality meeting. Hazard identification forms and a hazard register are in place and have been reviewed as part of the staff/quality meetings.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data on forms and enters them into a register. All incidents and accidents are collated, and results are discussed at the monthly/quality meetings (link 1.2.3.6).</p> <p>Ten incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The service supervisor and lead RN collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>There was evidence of comprehensive follow-up for high risk events including one which included immediate GP follow-up and subsequent mental health involvement. Nursing care included a short-term care plan, fifteen-minute observations and additional supervision for the resident.</p> <p>Reportable events have been reported where required.</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>	PA Moderate	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Six staff files reviewed (two registered nurses, two healthcare assistants, one activities staff member and the cook), evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. New staff are buddied for a period of time and during this period they do not carry a clinical load. Healthcare assistants reported that they feel very supported in their role.</p> <p>There is a bi-annual education and training schedule being implemented. Significant, informal opportunistic education is provided during staff meetings and has included communication, toileting, fingernail care, and chemical safety as examples. The bi-annual formal training and informal training has not covered all compulsory subjects in the last two years.</p> <p>There are eighteen healthcare assistants; eight have completed the dementia standards five are in the process and five new staff have yet to register. There are three registered nurses, one has completed interRAI training and one is currently in the process.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing levels meet contractual requirements. Interviews with the staff and relatives confirmed staffing overall was satisfactory.</p> <p>The staffing includes; the owner/manager Monday to Friday and the non-clinical supervisor, Monday to Friday. A registered nurse is on duty for the AM and PM shift Monday to Sunday and also one RN for the majority of night shifts.</p> <p>For all AM and PM shifts there are four HCAs, two are designated for resident care and two to assist with housekeeping and laundry. There is also an additional kitchenhand for tea assist for the PM shift. There are two HCAs for the night shift. RNs and HCAs interviewed stated that resident care is a first priority for all staff, with the staff designated for housekeeping and laundry assisting with resident care.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrated service integration. Entries are legible, timed, dated and signed by the relevant HCA or nurse, including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is a policy for resident admissions that includes a requirement for a needs assessment and approval for dementia level of care. The service communicates with needs assessors and other appropriate agencies prior to the resident's admission regarding the level of care requirements. Five long-term resident files reviewed had a needs assessment that had been approved by the older persons mental health service. The sixth file was for a resident under a CTO.</p> <p>The service has an 'information pack for residents/families' at entry. The pack includes all relevant aspects of service delivery within a secure environment. Six family members interviewed stated that they had received sufficient information prior to and on entry to the service. Admission agreements are signed and in place for five long-term resident files reviewed.</p>
<p>Standard 1.3.10: Transition,</p>	FA	<p>The service has transfer/discharge/exit policy and procedures in place. The procedures include a transfer/discharge form and all documentation accompanies the resident. The RNs reported that they</p>

<p>Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>inform families of any transfers to hospital or other providers.</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>There are policies available for safe medicine management that meet legislative requirements. Registered nurses and senior HCAs who administer medications have been assessed for competency on an annual basis (link 1.2.7.5). Education around safe medication administration has not been provided annually (link 1.2.7.5). Staff were observed to be safely administering medications including signing for medications on the electronic system at the time of administration. Registered nurses interviewed could describe their role regarding medication administration. The service currently uses robotic rolls for regular medication and blister packs for 'as required' medications. All medications are checked by an RN on delivery against the medication chart and date of checking entered into the electronic medication system. Any discrepancies are fed back to the supplying pharmacy. All medications were stored appropriately and within the expiry dates. Lakewood is a secure dementia unit and there are no self-medicating residents. The service does not use standing orders. The medication fridge temperature is recorded daily and is maintained within an acceptable range. Medication room air temperatures are recorded twice weekly.</p> <p>Twelve medication charts were reviewed. 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. The effectiveness of 'as required' medications was recorded on the electronic medication system.</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>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. The Monday to Friday cook and weekend cook are supported by morning and afternoon kitchenhands. There are four weekly rotating summer and winter menus which have been reviewed by the dietitian May 2018. Meals are cooked and held in a bain marie until plated and served to residents in the adjacent dining room. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated. Soft, pureed meals are provided as assessed by the RN/dietitian. Resident weights are monitored monthly and the cook is notified of any residents with weight loss. Drinks and snacks are available over 24/7 for residents such as sandwiches, jellies, puddings, yoghurts, ice-cream and sweet treats.</p> <p>The service has a food control plan verified July 2019 for two years. Fridge and freezer temperatures are checked and recorded daily. End-cooked food temperatures are documented daily. Inward goods and chilled goods are checked for acceptable temperatures and recorded. All foods were stored correctly, and</p>

		<p>date labelled. A cleaning schedule is maintained. The dishwasher is serviced monthly by the chemical provider.</p> <p>Feedback on the meals is through observation of residents at mealtimes and direct communication with residents as able. Family meetings and surveys provide an opportunity for relative feedback on the food service. Families interviewed stated they were satisfied with the food service.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents is recorded should this occur and communicated to the potential resident (as appropriate)/family, and the referring agency would be advised when a potential resident is declined access to the service. Reasons for declining entry would be if there was no bed available or the service could not meet the assessed level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The information gathered on admission is used to develop care plans and supports the individualised care for the residents. Risk assessment tools including behaviour assessments are completed on admission and reviewed at least six monthly. InterRAI assessments have been completed within 21 days for all resident files reviewed (including the resident under CTO) and have been completed at least six monthly. The outcomes of interRAI assessments and paper-based risk assessments were reflected in the long-term care plans reviewed. The diversional therapist completes a social history and assessment which informs the activity care plan in consultation with the resident/family.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Low	<p>The resident files reviewed were resident focused, integrated, and promoted continuity of service delivery, however not all care plans documented current supports and guidelines for staff. All resident files included an initial care plan developed in consultation with the family, allied health professionals' input and information from discharge summaries. All files had a long-term care plan in place that reflected the outcomes of interRAI and risk assessments. Behaviour management plans included potential behaviours, triggers and interventions/de-escalation techniques including activities to re-direct the resident from challenging behaviours. Short-term care plans were in place for acute and short-term conditions and had been evaluated on a regular basis and either resolved or transferred to the long-term care plan as an ongoing problem.</p> <p>Family members interviewed confirmed they had been involved in the care planning development and</p>

		<p>review process. Short-term care plans were in place for acute and short-term conditions and had been evaluated on a regular basis.</p> <p>The files included allied health involvement in the care of the residents including GP, dietitian, older person mental health team, pharmacist and podiatrist.</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>	PA Low	<p>Registered nurses and healthcare assistants (HCA) follow the care plan and report progress against the care plan each shift at handover. Interviews with registered nurses and healthcare assistants demonstrated an understanding of the individualised needs of residents. When a resident condition changes the RN accesses GP or specialist nursing advice or visit. Family are notified of any changes to the resident's health including medication reviews, GP visits, accidents/incidents, infections and behaviours of concern. Short-term care plans document interventions required for short-term problems. Not all interventions had been implemented.</p> <p>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. There were five wounds on the day of audit including a vascular ulcer. Wound care plans in place identified an initial wound assessment with size of wound, however there was no ongoing monitoring of the size of wounds. One wound (photographed) on an outer ankle had not been identified as a stage two pressure injury (also link 1.2.7.5). The GP reviewed wounds as per medical notes. The vascular service had been involved for the resident with a vascular ulcer. The wound nurse at Nurse Maude is available for any advice or support regarding wound care.</p> <p>Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described.</p> <p>There was evidence of monitoring charts in use (but not limited to), 15 minutes checks, food and fluid charts, blood glucose level monitoring, bowel monitoring, neurological observations, weight monitoring, pain monitoring and behaviour charts.</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,</p>	FA	<p>The service employs a qualified diversional therapist, five days a week, from 9 am to 5 pm. The DT attends the regional DT support groups and has attended the dementia conference in 2018. The activity programme is provided across the seven-day week with HCAs incorporating activities as part of their role over the 24 hours. There are plenty of resources available.</p> <p>Activities planned for the day are displayed on the noticeboard. 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) ball/balloon exercises, tenpin bowls, skittles, group walks, reminiscing, painting, arts and crafts, board games, happy hours, singalongs and gardening. One-to-one support is provided where residents are</p>

and the setting of the service.		<p>unable to participate in group activities such as foot spas, hand massage, discussions. Meaningful household activities include folding of washing, sorting, household chores and gardening. There are entertainers twice weekly, one resident sings and entertains the other residents. There is one main lounge where group activities occur and two smaller lounges for quieter activities. Community visitors include RSA, church groups, hairdresser, Salvation Army choir and pet therapy. There are two home cats and the acting managers dog on site daily. Festivities and theme days are celebrated.</p> <p>There are small group daily outings Monday to Friday (weather permitting). An HCA accompanies the DT on outings. The DT has a current first aid certificate. There has been good attendance at the family meetings.</p> <p>A social history and resident profile are completed on admission and a 24-hour activity plan is developed in consultation with the resident (as appropriate) and the family. Activity progress notes are maintained. The resident's activities plan is evaluated six monthly and documents progress towards meeting individual goals.</p> <p>Six family members interviewed spoke positively of the programme and the outings provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>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. Written evaluations identify if the resident goals have been met or unmet. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, the service responds by initiating changes to the care plan (link 1.3.5.2). The relatives are involved in the evaluation process as confirmed on interviews.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>The service facilitates access to other services (medical and non-medical) and where access occurs, referral documentation is maintained. Relatives are involved in referral options to other services as required. The clinical registered nurse interviewed described the referral process should they require assistance from specialist practitioners. The review of resident folders included evidence of recent referrals.</p>
Standard 1.4.1: Management	FA	There are policies in place for waste management, waste disposal for general waste and medical waste

<p>Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>management. There is an approved sharps container for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals. Chemicals are stored in a locked area until required. There is a pre-mixing system for the refilling of chemical bottles. Safety datasheets and products sheets are available. Gloves, aprons, and face shields are available for staff. Staff have completed chemical safety training.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness which expires on 1 June 2020. The acting manager oversees the maintenance programme. A maintenance log is used for maintenance requests which are addressed and signed off when complete. A handyman is available for small repairs. Corrective action plans are completed for repairs. There are essential contractors available 24 hours. A planned maintenance diary is maintained for testing and tagging, hot water checks, equipment calibrations and environmental maintenance. Hot water temperatures are recorded and are below 45 degrees Celsius. Contractors maintain gardens and grounds.</p> <p>The service is well maintained with home-like décor and furnishings. There is a large communal lounge and two smaller quiet lounges. There is easy access to the outdoors with ramps and rails. The unit has a secure garden and walking pathways. Residents were observed to be freely accessing the outdoor areas on the day of audit. The exterior is well maintained with safe paving, outdoor seating and shade.</p> <p>Interviews with HCAs confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal</p>	FA	<p>There are several rooms with shared ensuite facilities. There are adequate communal toilets and showers provided. Facilities were viewed to be kept in a clean and hygienic state. Privacy curtains for shower rooms were in place. The communal toilets and showers were well signed and identifiable with large vacant/in-use signs. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment. Family interviewed stated the resident's privacy and dignity is maintained while attending to their personal cares and hygiene.</p>

hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>The rooms are of sufficient size to meet the assessed resident needs. All rooms are single occupancy. Residents are able to manoeuvre mobility aids around the bed and personal space. All beds are of an appropriate height for the residents. HCAs interviewed reported that rooms have sufficient space to allow cares to take place. The bedrooms are personalised.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>There is a large lounge with seating arranged to allow small group activities or larger group activities. There are two smaller lounges where quieter activities can take place or visitors may use. The dining room is adjacent to the kitchen. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely throughout the audit and could freely access the outdoors.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Lakewood rest home has documented systems for monitoring the effectiveness and compliance of the cleaning and laundry service. There is a separate laundry area where all linen and personal clothing is laundered by a designated staff member from 7 am to 2.30 pm. There is a defined clean/dirty area. The sluice tub is within the laundry. There is appropriate protective clothing available. A care staff member completes cleaning duties after their morning resident cares have been completed. The cleaning trolley is kept in a locked room when not in use. Manufacturer's data safety charts are available. The chemical provider monitors the laundry and cleaning processes and the effectiveness of chemicals. Families interviewed reported satisfaction with the laundry service and cleanliness of the room/facility.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Appropriate training, information, and equipment for responding to emergencies is provided.</p> <p>There is a civil defence and emergency plan in place. The civil defence kit is readily accessible and includes torches, batteries, lamps, Hi-Viz vests and radios. The facility is well prepared for civil emergencies and has emergency lighting, a generator, stored water and access to an adjacent artesian well, gas stove, gas heater and a gas BBQ for alternative heating and cooking.</p> <p>Emergency food supplies, sufficient for three days, are kept in the kitchen. At least three days stock of other products such as incontinence products and PPE are kept. There is a store cupboard of supplies</p>

		<p>necessary to manage a pandemic. The call bell system is available in all areas.</p> <p>There are emergency management plans in place to ensure health, civil defence and other emergencies are included.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All communal areas and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated with ceiling heating in resident rooms and night store heaters in communal areas. The facility has adequate ventilation. Family interviewed stated the environment is warm and comfortable.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control programme and its content and detail is appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator is a registered nurse and is responsible for infection control across the facility. The infection control programme is well established at Lakewood. The infection control committee is part of the staff meeting and there is external input as required from general practitioners and the gerontology nurse specialist. There was a diarrhoea outbreak during 2018 and a recent norovirus that was well managed.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Lakewood. The infection control team is representative of the facility. External resources and support are available through the gerontology nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines. It defines roles, responsibilities and oversight, the infection control team, training and education of staff and</p>

<p>procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>scope of the programme.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Infection control training has not been held (link 1.2.7.5).</p> <p>The infection control coordinator has received education both in-house and is booked to undertake external training (she is new to the role). The infection control coordinator has access to the DHB nurse specialist and the GPs for advice.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility (link 1.2.7.5).</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the general practitioners. Systems in place are appropriate to the size and complexity of the facility.</p> <p>Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Corrective actions are established where trends are identified, but not documented as followed up (link1.2.3.6).</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The use of enablers and restraint is reviewed through internal audits and facility meetings. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>On the day of audit, the service had one resident using restraint in the form of an over chair table for meals and no residents with enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>There is a documented policy and procedure around restraint and the use of enablers. The restraint coordinator is a registered nurse. The restraint assessment includes a review of all alternatives and discussion with the family and GP. This process is documented and includes a consent form. The one resident with restraint had a well-documented restraint assessment and consent process documented in their file.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>The RN restraint coordinator with the resident's family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, GP and family discussions and on observations from the staff. The restraint file reviewed included a restraint assessment tool. The care plan reviewed was up-to-date and included the use of the restraint. Ongoing consultation with the family/whānau is also identified.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe.</p> <p>The resident file reviewed referred to specific reason for the use of restraint during meals. Risks were not identified (link 1.3.5.2). Restraint use is reviewed through the three-monthly evaluation, and six-monthly multidisciplinary meeting and includes family/whānau input. A restraint register is in place.</p>

<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation has occurred three monthly as part of the ongoing reassessment for the residents on the restraint register, and as part of their care plan review. The family is included as part of the review. Evaluation timeframes are determined by risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	FA	<p>Individual approved restraint is reviewed at least monthly by the restraint coordinator and is discussed in monthly staff meetings. The facility is proactive in minimising restraint usage. A review of the monitoring form for the one resident with restraint documented that the over chair table is only used for meals as per the care plan.</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)
Criterion 1.1.10.7 Advance directives that are made available to service providers are acted on where valid.	PA Low	Six resident files reviewed, evidenced family members had made the resuscitation decision for residents who were deemed incompetent to make a decision.	All files reviewed evidenced the resuscitation decision for CPR had been made by a family member. There was no evidence of GP involvement in the resuscitation decision.	Ensure relatives are not making ‘not for resuscitation’ decisions. 60 days
Criterion 1.2.3.6 Quality improvement data are	PA Low	There is a documented internal audit schedule that covers all aspects of service delivery, not all audits have been documented as undertaken as per schedule or reported to monthly meetings. Incidents and accidents and infection control data are reviewed	(i). Internal audits have not always been undertaken as per the schedule, examples include; medication audit (May), the behaviours that challenge audit and	(i). Ensure that the internal audit schedule is undertaken as per

<p>collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>		<p>monthly and a comprehensive report and action plan documented. Both infection control statistics and incident and accident statistics are reported to meetings monthly, however the report and action plan are not documented as reported and the action plans are not documented as followed up and signed off when completed.</p>	<p>informed consent audit (June), and audits have not been reported to meetings (all monthly meetings). (ii). Monthly reviews and reports for infection control and incidents and accidents are not reported to meetings and action plans have not been followed up and signed off as completed.</p>	<p>schedule and outcomes reported to meetings. (ii). Ensure that the infection control and accident action plans are reported to the meetings and that the action plans are followed up and signed off. 90 days</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Moderate</p>	<p>There is a documented training schedule and policy in place, with additional training provided during meetings. Not all compulsory training has been provided in the last two years and the content of documentation is not documented.</p>	<p>(i). A review of the last two years training evidenced that the following subjects have not been provided to staff; abuse and neglect, wound care, open disclosure, infection control and medication. (ii). The content of training provided has not been documented.</p>	<p>(i)-(ii) Ensure that all training is provided, and the content of training is documented. 90 days</p>
<p>Criterion 1.3.5.2</p>	<p>PA Low</p>	<p>All six files reviewed contained a long-term care plan that identified the resident/relative goals of care and support</p>	<p>(i) The long-term care plan for one resident did not reflect the residents</p>	<p>Ensure the long-term care</p>

<p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>		<p>required to achieve the desired goals, however not all interventions were documented to meet the current supports required.</p>	<p>current dietary requirements as identified on the written evaluation; (ii) There was no diabetes management plan in place (signs/symptoms, treatment and management) for one insulin dependent diabetic; and (iii) There were no documented risks associated with the use of a restraint for one resident.</p>	<p>plan meets the current supports/needs for the resident.</p> <p>90 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 Low</p>	<p>Wound assessments had been completed for five wounds which included the size of wounds on assessment, however wound size had not been ongoing. Photographs had been taken. Wounds had been evaluated at the documented frequency. One wound had not been identified as a pressure injury. Monitoring includes 15-minute checks for residents at risk of absconding or high falls risk, but these checks had not been implemented as per the care plan for one resident at high risk of falls. One resident did not have a behaviour chart in place for behaviours of concern requiring GP involvement and medication review.</p>	<p>(i). Wound assessments for five wounds reviewed included an initial size, but there were no further recordings to monitor the healing or non-healing process. Photographs taken did not demonstrate the size of the wound. One wound on an outer left ankle had not been identified as a stage two pressure injury from shoes. (ii). There was no behaviour chart in place to document behaviours as described in progress notes. The GP was required to review the resident and commence 'as required' medications for the management of confusion/sundowning in the afternoons. (iii). One resident at high risk of falls did not have 15-minute checks completed as per the care plan.</p>	<p>(i). Ensure wound sizes are taken and documented regularly throughout the healing process and ensure wounds are correctly identified and documented. (ii). Ensure behaviours of concern are documented on a behaviour monitoring chart to monitor the effectiveness of interventions. (iii). Ensure</p>

				that 15-minute checks are completed for residents identified at risk. 90 days
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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.