

Karaka Court Limited - Woodlands of Feilding

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Karaka Court Limited
Premises audited:	Woodlands Of Feilding
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 September 2019 End date: 19 September 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:	75

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

Karaka Court Limited - Woodlands of Feilding Home; owns and operates Woodlands of Feilding.

The service provides care for up to 80 residents. On the day of audit, there were 75 residents. All but one of the residents were under the age-related residential care services agreement, one resident was funded through the younger person disabled contract.

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

The clinical facility manager has significant experience in health management and is an experienced registered nurse. She is supported by a clinical coordinator, also an experienced registered nurse. The company director also plays a role in management.

The service has a business plan, which is reviewed annually. The service has quality goals, which have been reviewed regularly.

Four of six shortfalls identified as part of the previous audit have been addressed. These were around; staffing levels, timeframes for nursing documentation, activities and kitchen services. There are continued shortfalls around training and nursing interventions.

This audit has also identified a further shortfall around the internal audit process.

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.

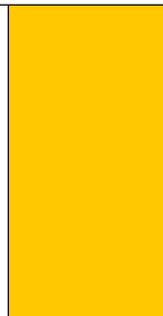


Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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.

There is a business plan with goals for the service that has been regularly reviewed. Woodlands of Feilding has a documented quality and risk system. Quality data is collated for accident/incidents, infection control, 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 programme that provides staff with relevant information for safe work practices. There is a staffing policy in place.

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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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans were in place for all residents and included family/whānau involvement where appropriate. There is a medication management system in place that follows appropriate administration and storage practices. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the activity staff. All meals are prepared on site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated, and the residents and relatives reported satisfaction with the food service.

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.

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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The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints and twelve with enablers at the time of the audit.

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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	13	0	1	2	0	0
Criteria	0	38	0	2	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 1.1.13: 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, and complaint forms are available in the foyer. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. There have been three complaints made since the previous audit. All complaints have been managed in line with Right 10 of the Code.</p> <p>A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Five residents (three hospital including one younger person and two rest home) 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>There is a policy to guide staff on the process around open disclosure. Interviews with the clinical facility manager, clinical coordinator, and two registered nurses confirmed family are kept informed. Two hospital relatives interviewed stated they are notified promptly of any incidents/accidents and any changes to residents' health status.</p> <p>Communication with families continues to be well documented. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Five resident files reviewed included family contact sheets. Twelve accident/incident forms reviewed evidenced relatives are informed of any</p>

communication.		<p>incidents/accidents.</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. There is access to an interpreter service as required.</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>Karaka Court Limited - Woodlands of Feilding Home owns and operates Woodlands of Feilding. The service is managed by a clinical facility manager who is supported by the company director and a clinical coordinator. The clinical and facility manager is a registered nurse, who is experienced in elderly care. She has been in the role for six months.</p> <p>The service provides care for up to 80 residents in two separate wings of 40 beds each. All the beds are dual-service beds (hospital and rest home). On the day of audit, there were 75 residents; 49 rest home and 26 hospital level including one younger person disabled. All other residents were under the ARC contract.</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business and the inclusion of adding hospital services. The service has quality goals, which have been reviewed regularly.</p> <p>The clinical facility manager and director have not completed at least eight hours of professional development (link to 1.2.7.5).</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>Woodlands of Feilding has a documented quality system. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff; three caregivers, two registered nurses, the cook and an activities person, confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support hospital level care.</p> <p>There is an internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001, however not all audits have been completed as per schedule. Corrective actions are developed, implemented and signed off for completed audits.</p> <p>Quality matters, including health and safety are taken and discussed at the two monthly staff meetings and two monthly registered nurse meetings. There are monthly resident meetings. Meeting minutes demonstrated key components of the quality management system discussed including internal audit, infection control, incidents (and trends) and in-service education. Monthly accident/incident reports, infections and results of internal audits (when completed) are tabled at meetings. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicated issues raised are followed through and closed out.</p>

		<p>An annual survey of residents and relatives is undertaken, the most recent was August 2018 with very good/excellent results reported, a food survey during July was completed and results communicated to the July residents meeting.</p> <p>There is a H&S and risk management programme in place including policies to guide practice. A hazard register is in place.</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. Monthly reports are discussed at the facility meetings.</p> <p>Results are also posted up in the staff room for staff to read. Twelve 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 caregivers interviewed could discuss the incident reporting process. The clinical manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The clinical manager interviewed could describe situations that would require reporting to relevant authorities. There has been no reportable event since the previous audit.</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 to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs and three caregivers). Performance appraisals were not up to date for all staff files reviewed. Current practising certificates were sighted for the registered nurses. All required staff have been employed and appropriate employment practices followed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. Staff interviewed believed new staff are adequately orientated to the service on employment.</p> <p>There is an annual education planner in place; all attendance at compulsory training is now paid. Compulsory training has been provided and booked for upcoming months. This is an improvement from the previous audit, however management access to training related to managing a rest home/hospital is a continued shortfall. The planner and individual attendance records are updated after each session. Six of the ten registered nurses have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical facility manager have completed syringe driver training and have access to external clinical training.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a policy that determines staffing levels and skill mixes for safe service delivery. The service continues to review staffing and there is evidence of changes to staffing since the previous audit. Residents and relatives reported that the staffing was satisfactory. Staff stated they feel supported by the RNs and clinical facility manager who respond quickly to after-hour calls.</p> <p>The service is divided into two wings; Totara and Karaka. Both wings have a capacity of 40 dual-purpose beds.</p> <p>On the days of audit, the service had 36 residents in Karaka, 12 of which were hospital level, and 39 residents in Totara, 14 of which were hospital level.</p> <p>The roster includes the clinical facility manager working five mornings a week and the clinical coordinator four mornings a week. The two managers are both on call. There is at least one RN and one first aid qualified person on each shift.</p> <p>Each wing has the same staffing including;</p> <p>An RN each shift for each wing.</p> <p>For each shift there are the following caregivers in each wing; AM) two long shift and two short, PM) two long shift and two short and one caregiver at night.</p> <p>Care staff reported that process had improved, and they were able to safely care for residents. This is an improvement from the previous audit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management system includes medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The service uses an electronic medication system. All residents have individual medication orders with photo identification and allergy status documented. 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. Short-life medications (ie, eye drops and ointments) are dated once opened.</p> <p>Education on medication management has occurred with competencies conducted for the registered nurse and senior caregivers with medication administration responsibilities. Administration sheets sampled were appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. A registered nurse was observed administering medications and followed correct procedures. No residents self-administer medications, procedures are in place if needed.</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>There is a fully equipped commercial kitchen, which is located centrally in the facility. The majority of food is prepared and cooked on site. The service employs two cooks who are supported by kitchen staff. All kitchen staff have completed food safety training. There is a five-weekly rotating menu in operation. The menu has been approved by a dietitian. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines and a food control plan approved. Stock rotation of food was evidenced, and the kitchen was clean. This is an improvement from the previous audit. The service maintains two bulk food stores, one frozen and one dry goods. Kitchen staff advised that they were able to access the stored food as needed. This is an improvement from the previous audit</p> <p>Fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. A tray service is available if required by residents. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for. Alternative meals can be accommodated if needed. Residents' weights are recorded routinely each month or more frequently if required. Residents and relatives interviewed reported satisfaction with food choices and meals, which were well presented.</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>Five resident files were reviewed for this audit; two rest home level and three hospital, including one younger person's file and care plan. Care plans sampled were goal orientated using a care plan template developed by the management team. The care plan template is designed to reflect interRAI assessments. Care plans reviewed referred to all assessed needs from the interRAI. However, the interventions to support the assessed needs were not always addressed in the care plan and monitoring was not always documented in the care plan or consistently documented as implemented. This is a continued shortfall from the previous audit. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p> <p>There were ten wounds logged at the time of the audit. This included three, stage two pressure injuries (two are facility acquired). Assessments, management plans and documented reviews were in place for all wounds.</p> <p>Specialist nursing advice is available from the DHB as needed. A physiotherapist is available as needed by referral. Two GPs visit the service, they provide two visits a week between them and on call, and more visits as needed.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were not consistently completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care.</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>There are two diversional therapists employed who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. The team implements an activity programme for the rest home/hospital Monday-Friday. The programme has set activities with the flexibility to add activities that are meaningful and relevant for all cognitive and physical abilities of the resident group and are gender appropriate. The programme is also displayed throughout the facility.</p> <p>Activities were observed to be delivered along with input from volunteers. There is a van to facilitate outings to events for residents (as appropriate). Visits from entertainers occur monthly and there are a wide range of visiting speakers. On site church services are held in the facility chapel room. The programme also includes exercise sessions and a range of intellectual, craft and fun activities.</p> <p>The resident/family/whānau as appropriate, are involved in the development of the activity plan and a number of relatives actively participate. All care plans reviewed included an activity plan; this is an improvement from the previous audit. The younger person disabled at the service was over 65 and happily joined in activities. Resident/relative meetings were held monthly.</p> <p>Residents and relatives expressed satisfaction with activities offered.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. The interRAI assessments and documented evaluations of care were up to date in files reviewed. 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. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</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>	<p>FA</p>	<p>The building has a building warrant of fitness expiring 9 January 2020.</p> <p>One of the Karaka Court Trust members provides maintenance services to Karaka Court Ltd. There is a proactive maintenance schedule for 2018– 2019. Daily maintenance requests are addressed, and electrical testing, calibration and functional checks of medical equipment has been completed by an external contractor. Hot water temperatures in resident areas are monitored. Contractors are available 24 hours for essential services.</p> <p>The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is a range of seating and activity areas (including a chapel, a library and a dedicated room for family functions) for</p>

		residents and families to use. Fixtures, fittings and furnishing are all new and along with the level of lighting is suitable for residents. Residents were observed to access the outdoor gardens safely. Seating and shade are provided. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134. The policy includes comprehensive restraint procedures and identifies that restraint be used as a last resort. The service is currently restraint free. There were 12 residents with enablers (all bedrails). Not all monitoring forms had been consistently completed (link 1.3.6.1). Restraint use is included in orientation for clinical staff. Challenging behaviour and restraint minimisation and safe practice education is provided.

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	There is an internal audit schedule documented, however this has not been fully implemented since the previous audit.	Internal audits for May, June and July have not been documented as undertaken. The clinical coordinator reported that the responsibility for the audits was unclear.	Ensure that the responsibility for internal audits is clear and that internal audits are documented as per schedule. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing	PA Low	The service has a two-yearly education programme. Since the previous audit the service has commenced paying for staff attendance at training and this has improved	(i). The clinical facility manager has not attended at least eight hours training related to managing a rest home/hospital. (ii). Two of five staff files reviewed did not have an up to date annual	(i). Ensure the manager attends training related to

<p>education for service providers to provide safe and effective services to consumers.</p>		<p>attendance. Access to management training for the clinical facility manager is a continued shortfall. There is a process for annual appraisals for staff, but this was not up to date at the time of audit.</p>	<p>appraisal. Since the draft report the owner has advised that the Clinical Manager is attending the ARC meeting on the 6th Nov and will continue these next year and all appraisals are now up to date.</p>	<p>managing a rest home/hospital. (ii). Ensure staff have a documented annual appraisal. 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 Moderate</p>	<p>All five resident files included a care plan. Discussion with care staff and family evidenced that care is delivered according to need. Caregivers confirmed that handovers provided them with information to effectively care for residents. Care needs were not always fully documented in care plans and monitoring/ongoing care was not always documented as provided.</p>	<p>(i). One hospital level resident did not have the care plan updated to reflect the fluid diet. This resident also did not have repositioning implemented as directed on the monitoring chart and the fluid chart completed as directed by the speech language therapist. (ii) One hospital level resident did not have interventions to safely manage behaviours that challenge. (iii) The monitoring needs around the use of enablers was not documented in the care plan for three hospital and one rest home resident. Monitoring was not consistently documented for these residents.</p>	<p>(i)-(iii) Ensure that resident's care plans reflect their current assessed needs. Ensure that monitoring is documented according to instruction. 60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.