

Waikanae Country Lodge Limited - Waikanae Country Lodge

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: Waikanae Country Lodge Limited

Premises audited: Waikanae Country Lodge

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 18 May 2018 End date: 18 May 2018

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 57

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

Arvida Waikanae Country Lodge is part of the Arvida Group. The service is certified to provide rest home and hospital level care for up to 79 residents. On the day of the audit, there were 57 residents.

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

There is a village manager who reports to the Arvida group Board of Directors. The service has a clinical manager who is an experienced registered nurse. The relative and residents interviewed all spoke positively about the care and support provided at Arvida Waikanae

The one shortfall identified at their previous audit around service provision remains an area for improvement.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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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 member 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.		Standards applicable to this service fully attained.
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Waikanae Country Lodge is implementing a quality and risk management system that supports the provision of clinical care. Quality activities are conducted which generates opportunities for improvement. Corrective actions are developed and implemented. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses, plans and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrated service integration and were evaluated at least six-monthly. InterRAI assessments are utilised. Resident files included medical notes by the general practitioner and visiting allied health professionals.

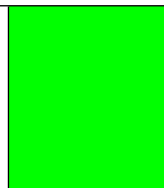
Medication policies reflect legislative requirements and guidelines. Registered nurses responsible for administration of medicines complete education and medication competencies. The medicine charts were reviewed at least three-monthly by the general practitioner.

An integrated activity programme is implemented for residents at rest home and hospital level of care. The programme includes community visitors and outings, entertainment and activities that meet the individual physical, cultural and cognitive abilities and preferences for each resident group.

All meals are cooked on-site. Residents' food preferences and dietary requirements are identified at admission. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

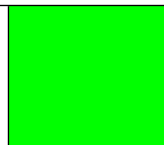


Standards applicable to this service fully attained.

The building holds a current 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.

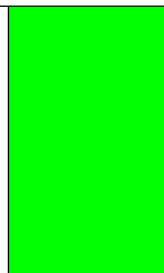


Standards applicable to this service fully attained.

The service has policies and procedures to ensure that restraint is a last resort. At the time of the audit there were two residents with restraints and four residents using enablers. Staff receives training in restraint minimisation.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	1	0	0
Criteria	0	40	0	0	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 service has a complaints policy and procedure in place and residents and their family/whānau are provided with information on the complaints process on admission via the information pack. Complaint forms are available at each entrance of the services. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is in place. There have been fourteen complaints made in 2017 and two received in 2018 year to date. The complaints reviewed had been managed appropriately with acknowledgement, investigations and responses recorded. Residents and family member advised that they are aware of the complaints procedure and how to access forms. One of the complaints was made through the district health board (DHB) in 2017. A corrective action plan implemented in November 2017 was followed up and completed around staff palliative care training, regular general practitioner (GP) reviews for any high complex health residents and reviewing pain relief administration (link 1.3.5.2). A response from the DHB in April 2018 confirmed that the complaint would not be taken any further.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Six residents (four rest home and two hospital) interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incident/accidents had documented evidence of family notification or noted if family did not wish to be informed. One family member (hospital) interviewed confirmed that</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>they are notified of any changes in their family member's health status. Interpreter services are available 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>	<p>FA</p>	<p>Waikanae Country Lodge is owned and operated by the Arvida Group. The service provides care for up to 79 residents with 59 dual-purpose beds (rest home/hospital) and up to 20 serviced apartments certified to provide rest home level care. On the day of the audit, there were 57 residents in total. There are 20 residents at rest home level, including 1 resident on respite care and 35 residents at hospital level care, including 1 resident on a long-term support chronic health condition (LTS-CHC) contract. There were two rest home residents in the serviced apartments. All other residents were admitted under the aged related residential care contact (ARRC).</p> <p>The village manager has been in the role since December 2013 and is an experienced manager. She is supported by a clinical manager who has been in the position since January 2018 with five years' experience in similar positions in NZ. The village manager and clinical manager are supported by the general manager operations, general manager wellness and a national quality manager.</p> <p>The village manager reports to the general manager operations on a variety of operational issues and provides a monthly report. Arvida has an overall business/strategic plan. The organisation has a philosophy of care, which includes a mission statement. Waikanae Country Lodge has a business plan for 1 April 2016 to 31 March 2019. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and head office as well as weekly meetings between the village manager and clinical manager.</p> <p>The village manager and clinical manager have completed in excess of eight hours of professional development in the past twelve months.</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</p>	<p>FA</p>	<p>There is a business plan that includes quality goals and risk management plans for Waikanae Country Lodge. Interviews with staff confirmed that there is discussion about quality data at various staff meetings. The village manager is responsible for providing oversight of the quality programme on site, which is also monitored at organisational level. The quality and risk management programme is designed to monitor contractual and standards compliance. Staff interviewed could describe the quality programme corrective action process. Head office sends new/updated policies which are available to staff on the intranet. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system that is regularly reviewed. Restraint and enabler use is reviewed within the quality and clinical staff meetings.</p> <p>Health and safety goals are established and regularly reviewed. Risk management, hazard control and emergency</p>

<p>continuous quality improvement principles.</p>		<p>policies and procedures are being implemented and are monitored by the Health and Safety Committee at the monthly health and safety meeting. Five representatives have received specific health and safety training in their role. Hazard identification forms and an up-to date hazard register are in place. Resident/family meetings occur bi-monthly and the residents and family member interviewed confirmed this. Residents/relatives are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. The overall service result for the resident/relative satisfaction survey completed in March 2018 increased from the previous year's result. Action plans have been developed in areas where improvements were identified, i.e. around food/meals and activities. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The clinical manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at staff meetings including actions to minimise recurrence. A registered nurse (RN) conducts clinical follow up of residents. Ten incident forms (eight hospital and two rest home) reviewed for April 2018 demonstrated that appropriate clinical follow up and investigation occurred following incidents. Discussions with the village manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There has been one section 31 incident notification completed since the last audit. The notification was around a stage III pressure injury in April 2018.</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</p>	<p>FA</p>	<p>There are human resources management policies in place. This includes that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. Six staff files were reviewed (one clinical manager, one RN, two caregivers, one diversional therapist and one kitchen manager). There is evidence that reference checks were completed before employment was offered. Annual staff appraisals were evident in all staff files reviewed. A copy of practising certificates is kept. The service has an orientation programme in place that provides new staff with relevant information for safe work practice.</p> <p>Completed orientation is on files and staff described the orientation programme. The in-service education programme for 2017 has been completed and the plan for 2018 is being implemented. The village manager, clinical manager and RNs are able to attend external training, including sessions provided by the district health board (DHB). Discussions with the caregivers and the RNs confirmed that ongoing training is encouraged and supported</p>

requirements of legislation.		by the service. Eight hours of staff development or in-service education has been provided annually. There are ten RNs at Waikanae and nine have completed interRAI training.
<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>Human resources policies include documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff are rostered on to manage the care requirements of the residents. The service has a total of 70 staff in various roles. Staffing rosters were sighted and there is staff on duty to match needs of different shifts. The village manager and clinical manager work 40 hours per week from Monday to Friday and are available on call after-hours. In addition to the village manager and clinical manager, there is at least one RN on at any one time. The RN on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family member confirm there are sufficient staff to meet the needs of residents. The caregivers interviewed stated that they have sufficient staffing levels.</p> <p>The service is split in to four wings, the south/west, north/west, south/east and north/east wings. In the south/west wing there are 23 of 24 residents in total (18 hospital residents and 5 rest home residents). There is one RN on duty in the morning and afternoon shifts, and one RN on the night shift. They are supported by four caregivers (two long and two short shifts) on the morning shift, three caregivers (two long and one short shifts) on the afternoon shift and one caregiver on the night shift. In the north/west wing there are nine of ten residents in total (eight rest home residents and one hospital resident). There is one caregiver on the morning and on the afternoon shifts. The RN from south/west wing covers the north/west wing on the morning, afternoon and night shifts.</p> <p>In the south/east wing there are 19 of 20 residents in total (16 hospital residents and 3 rest home residents). There is one RN on duty in the morning and afternoon shifts and one on the night shift. They are supported by four caregivers (two long and two short shifts) on the morning shift, three caregivers (two long and one short shifts) on the afternoon shift and one caregiver on the night shift. In the north/east wing there are four of five residents in total (four rest home residents and one hospital resident). There is one caregiver on the morning and on the afternoon shifts. The caregivers from the north/east wing cover the two rest home residents in the serviced apartments on the morning and afternoon shifts. The RN from south/west wing covers the north/west wing on the morning and afternoon and night shifts.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Registered nurses who administer medications have been assessed for competency on an annual basis. Annual education around safe medication administration has been provided. Registered nurses complete syringe driver training. There is one main medication room for the care centre and rest home residents in serviced apartments. Monthly delivery of medication blister packs is checked against the pharmacy generated medication charts by the RN on duty, as evidenced on the pharmacy checklist. The medication fridge is checked daily. All eye drops and ointments were dated on opening. There was one rest home resident self-medicating with a self-medication</p>

<p>current legislative requirements and safe practice guidelines.</p>		<p>assessment that had been reviewed three-monthly by the GP.</p> <p>Ten medication charts (four rest home and six hospital) reviewed had photo identification, allergy status and had been reviewed by the GP at least three-monthly. Signing sheets corresponded with the medication charts. Prescribing met legislative requirements and all 'as required' medication had an indication for use.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>All meals are prepared and cooked on-site by qualified cooks supported by a morning and afternoon kitchenhand. Food services staff have attended food safety training. The Arvida dietitian reviews the seasonal menu. Dietary preferences and special diets are met, including gluten free, dairy free, pureed meals and diabetic desserts. Resident dislikes are known and accommodated. The cook receives a resident dietary profile for new and respite care residents and is notified of any dietary changes. Holding temperatures of the bain marie meals are taken. Meals are served from the bain marie to residents in the main dining room adjacent to the kitchen. Meals are plated and transported in hot boxes to the hospital dining room.</p> <p>Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Perishable foods sighted in the fridges were dated. All dry goods were labelled with expiry dates. The dishwasher is checked monthly by the chemical supplier. A cleaning schedule is maintained.</p> <p>Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family member interviewed were satisfied with the meals and confirmed alternative food choices were offered for dislikes.</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>When a resident's condition alters, the registered nurse initiates a review and if required, GP and/or nurse specialist consultation. There is documented evidence on the family/whānau contact in the electronic system, that evidences family were notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications.</p> <p>Adequate dressing supplies were sighted in treatment room. Wound management policies and procedures are in place. Wound assessment and treatment forms, ongoing evaluation form and evaluation notes were in place for residents with wounds (skin tears, one chronic ulcer, and five pressure injuries). There were five facility-acquired pressure injuries (one stage I, three stage II and one stage III). The service has had the DHB nurse practitioner, GP and wound nurse involvement in the stage III pressure injury.</p> <p>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. The previous finding around monitoring has been addressed. Neurological observation forms were documented and completed for any unwitnessed falls and this is an improvement on previous audit.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management,</p>

		<p>and continence products identified.</p> <p>Short-term care plans had been completed on the electronic system for short-term needs that guided staff in the delivery of care. Not all interventions had been documented to meet the resident needs.</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>	FA	<p>The service employs a qualified diversional therapist (DT) and entertainment coordinator (DT in training) to coordinate and implement the integrated activity programme Monday to Saturday. Volunteers are involved in the activity programme and also implement the programme on alternate Saturdays. The programme is integrated. On the days where two activity staff are on, there are activities happening in the rest home and hospital, including one-on-one time with residents. Rest home residents in the serviced apartments are invited to attend the serviced apartment or care centre programme. The integrated programme offers choice and variety of activities for residents to attend, including crafts, board games, quizzes, cooking, skittles, bowls and exercises. There are entertainers, church services and visiting mums and babies to the facility. Residents attend community groups such as stroke club, Kapiti sing-a-long group and senior citizens. The service has a wheelchair hoist van and hires a mobility taxi as required for the weekly outings into the community, scenic drives and café outings.</p> <p>A resident profile "About Me" is completed on admission. Individual leisure activity plans were seen in paper-based and electronic system for new residents. The DT is involved in the six-monthly multidisciplinary review. The service receives feedback and suggestions for the programme through two-monthly resident meetings and surveys. Residents interviewed spoke positively about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the multidisciplinary team at least six-monthly or earlier for any health changes. Written evaluations (currently all paper-based) identified if the resident/relative desired goals had been met or unmet. Family are invited to attend the MDT review and informed of any changes if unable to attend. The GP reviews the residents at least three-monthly or earlier, if required. Ongoing nursing evaluations occur as indicated and are documented within the electronic progress notes.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical</p>	FA	<p>The building has a current building warrant of fitness that expires 30 November 2018. Reactive and preventative maintenance occurs.</p>

environment and facilities that are fit for their purpose.		
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on standard definition of signs and symptoms of infections. Short-term care plans are used for infections. Surveillance of all infections is entered into the monthly online infection control register. This data is monitored and evaluated monthly for trends and opportunities for improvements. Analysis of infections and corrective actions are discussed at the Infection Control Committee meetings. Benchmarking occurs within the Arvida group. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. At the time of the audit, there were two hospital residents with restraints (one bedrail and one chair brief) and four residents (three hospital and one rest home) using enablers (all bedrails). The files for four residents with enablers reviewed evidenced that enabler use is voluntary. Staff received training on restraint minimisation in March 2018.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired</p>	<p>PA</p> <p>Moderate</p>	<p>Monitoring occurs for weight, blood pressure, blood sugar levels, pain, neurological observations, food and fluid charts. The RN monitors and reviews the monitoring forms daily on the electronic system. Care staff report any changes to the RN. The RNs review the electronic daily work logs which includes such cares as position changes, food and fluid intake and toileting. There were no documented interventions to meet the resident needs in four of five files reviewed. This is an area that requires improvement.</p>	<p>There were no documented interventions for the following residents: (i) no pain management plan for one hospital resident who identified with chronic pain; (ii) no falls prevention strategies in place for one younger hospital level person with a high risk of falls; (iii) one rest home respite resident with a falls risk and wearing a moon boot did not have any falls prevention strategies in place; and (iv) one rest home resident with knee pain identified on interRAI did not have any pain management plan in place.</p>	<p>(i)-(iv)</p> <p>Ensure interventions and supports are documented to meet the resident's current needs.</p> <p>60 days</p>

outcomes.				
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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.