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: 7 February 2019 End date: 8 February 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: 79

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

General overview of the audit

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

The service provides care for up to 80 residents. On the day of audit, there were 79 residents. All the residents were under the age-related residential care services agreement.

This 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 facility manager has significant experience in health management and has been in the role for 24 years. The service is managed by a manager who is supported by a clinical nurse leader and a quality systems manager. 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.

One of the three shortfalls identified as part of the previous audit have been addressed. This was around fire evacuations. There are continued shortfalls around staff training and food service management.

This audit has identified four areas requiring improvement around: staffing levels, care plan interventions, care evaluation and activities.

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 Fielding has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides staff with relevant information for safe work practices. There is a staffing policy in place.

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.

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included 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 report satisfaction with the food service.

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.

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.

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 six residents using restraints and twenty 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.

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	10	0	4	2	0	0
Criteria	0	35	0	4	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	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 nine complaints made during 2018 and none so far for 2019. All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents (one rest home and two hospital) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes. One complaint involved the DHB, and a district nurse reviewed the issues raised. The outcome was accepted by the DHB and no further action taken.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	There is a policy to guide staff on the process around open disclosure. The facility manager, quality manager and clinical manager confirmed family are kept informed. Relatives interviewed (three hospital and three rest home) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. The most recent family survey, taken 2018 evidenced high satisfaction across all areas. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Eleven accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives

communication.		interviewed stated they are notified promptly of any changes to residents' health status. 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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Karaka Court Limited - Woodlands of Fielding Home owns and operates Woodlands of Fielding. The service is managed by a manager who is supported by a clinical nurse leader and a quality systems manager. The company director also plays a role in management. 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 79 residents; 57 rest home and 22 hospital level. All the residents were under the age-related residential care services agreement. 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. The facility manager has significant experience in health management and has been in the role for 24 years. The manager has not completed at least eight hours of professional development (link to 1.2.7.5).
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Woodlands of Fielding continues to implement the quality and risk programme. 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. There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. A three-monthly summary of internal audit outcomes is provided to the quality meetings for discussion. Corrective actions are developed, implemented and signed off. Quality matters, including health and safety are taken and discussed at the monthly quality/risk management meetings and also staff meetings. There are monthly resident meetings. Meeting minutes demonstrate 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 are completed. The service has linked the complaints/compliments process with its quality management system and communicates relevant information to staff. Meeting minutes reviewed indicate issues raised are followed

		through and closed out. An annual survey of residents and relatives is undertaken, the most recent was August 2018 with very good/excellent results reported There is a H&S and risk management programme in place including policies to guide practice. A hazard register is in place. Health & Safety policy has been reviewed and reflects current H&S legislation.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	The service collects incident and accident data on forms and enters them into a register. Monthly reports are discussed at the facility meetings. Results are also posted up in the staff room for staff to read. Eleven 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. The facility manager interviewed could describe situations that would require reporting to relevant authorities. The service has reported a medication error, a trespass order and a stage three pressure injury to the Ministry of Health.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	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 (one clinical manager, one RN, and three caregivers). All files contained relevant employment documentation including current performance appraisals and completed orientations. 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. There is an annual education planner in place but not all compulsory education requirements have been met. The planner and individual attendance records are updated after each session. Two of the ten registered nurses have completed interRAI training and this impacted on timeframes. Timeframes have since been rectified (link to 1.3.3.3). Clinical staff complete competencies relevant to their role. The RNs and clinical manager have completed syringe driver training and have access to external training.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	PA Low	There is a policy that determines staffing levels and skill mixes for safe service delivery. The service has reviewed staffing and there is evidence of increases to staffing as the resident numbers have increased. Residents and relatives stated there were not always adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical and facility manager who respond quickly to after-hour calls. The service is divided into two wings; Totara and Karaka. Both wings have a capacity of 40 dual-purpose beds. On the days of audit, the service had 40 residents in Karaka, 12 of which were hospital level and 39 residents in Totara, 10 of which were hospital level. The roster includes the clinical nurse leader working five mornings a week. The manager and clinical nurse leader are both on call. There is at least one RN and one first aid qualified person on each shift. Each wing has the same staffing including; An RN each shift for each wing. 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.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. The service used 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. Education on medication management has occurred with competencies conducted for the registered nurse and senior health care assistants 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.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management	PA Moderate	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

A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		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 (expiring May 2019). There was no evidence of a process that maintains a consistent stock rotation of food and cleanliness of the kitchen, this is a continued shortfall from the previous audit. The service maintains two bulk food stores, one frozen and one dry goods. Both of these stores are not accessible by staff 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.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Low	Six resident files were reviewed for this audit; four rest home level and two hospital. 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, the interventions to support the assessed needs were not always addressed in the care plan, nor were all needs associated with medicine use. 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. There were eight wounds logged at the time of the audit. One resident had a grade one and a grade two pressure injury. Assessments, management plans and documented reviews were in place for all wounds. 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. Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed. Residents and family members interviewed confirmed their satisfaction with care.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer,	PA Low	There are two activity staff employed who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. The service diversional therapist was on maternity leave at the time of audit. The team implements an activity programme for the rest home/hospital. 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

activity requirements are appropriate to their needs, age, culture, and the setting of the service.		facility. 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. The resident/family/whānau as appropriate, are involved in the development of the activity plan and a number of relatives actively participate, however not all care plans reviewed included an activity plan. Resident/relative meetings were held monthly. Residents and relatives expressed satisfaction with activities offered, but stated they were not always able to attend (link 1.2.7.5).
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	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 were up to date in files reviewed but documented six monthly evaluations were not (link to 1.3.3.3). 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.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a building warrant of fitness expiring 9 January 2020. One of the Karaka Court Trust members provides maintenance services to Karaka Court Ltd. There is a proactive maintenance schedule for 2017– 2018. 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. 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 residents and families to use. Fixtures, fittings, 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 is 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	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 three residents using bedrail restraints and 20 bedrails enablers at the time of the audit. One restraint care plan and one enabler care plan documented appropriate assessment, consents, care plan interventions and monitoring.

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 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The service has a two-yearly education programme. Shortfalls in education identified at the previous audit of: nutrition, wound care, cultural care and challenging behaviour have been addressed, however the service has not offered at least eight hours of training for the year 2018. Education provided for 2018 included; skin care and pressure area care, medication, diabetes and open disclosure. Attendance at training has also been low. The manager of Woodlands is very experienced in her role and is supported by a very experienced quality manager, however the manager has not attended training relevant to managing a rest home hospital.	(i). The service has not provided at least eight hours training for staff for 2018. (ii). Attendance at training is well below 50% of staff. (iii). The manager has not attended at least eight hours training related to managing a rest home/hospital.	(i). Ensure at least eight hours of training is provided for staff annually. (ii). Ensure that staff attend compulsory training. (iii). Ensure the manager attends training related to managing a rest home/hospital.

				90 days
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	There is a clearly documented staffing rational. Relatives and resident interviewed reported that staff were not always available, and residents were not always able to attend activities as staff were not always available to take them to the set activities. Caregiving staff reported very supportive management, however they reported that they find it difficult to ensure they can provide all care and they have additional roles. For example, the activities person undertakes the continence pad round and caregivers undertake laundry. A review of quality data indicates a consistently high unwitnessed falls rate month on month. Staff reported high acuity residents and the layout of the facility can make it difficult to attend all residents.	Residents, relatives and staff interviewed states that staffing levels did not meet the current resident acuity levels and layout of the facility.	Ensure staffing levels are reviewed to meet the current resident acuity levels and consider the layout of the facility. 60 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Moderate	The service employs two cooks who are supported by kitchen staff. There continues to be no evidence of a process that covers stock control of food consistently and cleanliness of the kitchen. The service maintains two bulk stores, one frozen and one dry goods. Both of these stores are locked, neither the cook, the manager or the care manager have access to these stores, with the key kept by the owner(s). Staff report that in the event that they need to access additional food they have to ring the owner.	(i)Staff are unable to access the food bulk stores in the freezer and pantry. (ii) Not all stored food and baking was labelled and dated. (iii) Containers of food in the dry store were not all not clearly labelled and there was no evidence of consistent dating and rotation. (iv) Food was observed to be stored on the floor. (vi) The ovens and the shelves were not clean.	(i)Ensure that staff can access the bulk stores of food. (ii) – (iii) Ensure all aspects of food procurement and storage complies with current guidelines. (iii) Ensure that the kitchen is maintained to a high standard of cleanliness. 60 days

Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	The service has commenced a process to ensure all new resident have a timely initial interRAI assessment and an ongoing process to align the six-monthly evaluations of care to the interRAI timeframes. New resident interRAI assessments and six-monthly evaluations of care are not within set time frames	(i)Two rest home and one hospital level resident did not have the initial interRAI within 21 days. (ii) One rest home and two hospital level residents did not have an up to date evaluation of care within the last six months.	(i)Ensure that new resident interRAI assessments are within 21 days of admission to services (ii) Ensure that resident's evaluation of care is documented six monthly 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	All six resident files included a care plan. Review of monitoring charts and discussion with care staff evidenced that care is delivered according to need. Caregivers confirmed that handovers provided them with information to effectively care for residents.	(i)One hospital and one rest home resident with identified behaviours that challenge had challenging behaviour documented in the care plan but no de-escalation strategies to manage the issue. (ii) One rest home resident prescribed warfarin, did not have the risk associated with warfarin in the care plan. (iii) one hospital resident did not have the care plan updated to reflect current needs including, the risks associated with warfarin, the use of oxygen therapy, and skin and pressure area care needed.	(i)-(iii)Ensure that resident's care plans reflect their current assessed needs. 60 days
Criterion 1.3.7.1 Activities are	PA Low	Group activities are provided over five days a week. The group activities are planned monthly and a weekly plan provided to residents and posted up onto noticeboards.	(i)One hospital and two rest home residents reported not being able to access the activities provided due to	(i)Ensure that residents are enabled to

planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.		Not all residents have an individual activity assessment and plan and not all residents reported that they are able to access the group activities.	staff not being available to assist them. (ii) Two rest home resident care plans did not include an individual activities assessment and plan.	access activities provided. (ii) Ensure that all residents have an individualised activities assessment and plan. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.