

Karaka Court Limited - Woodlands of Palmerston North

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 Palmerston North	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 19 February 2020	End date: 20 February 2020
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:	27	

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

Woodlands of Palmerston North is one of two facilities owned by Karaka Court Ltd. Woodlands of Palmerston North provides care for up to 38 residents at rest home and secure dementia level of care. On the day of audit there were 24 residents and three boarders.

This 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 service has a mission, business goals and quality goals that support the service goals of a family friendly service.

The service is managed by a non-clinical manager and a clinical nurse leader. Residents and relatives interviewed spoke positively about the service provided.

The previous shortfall around staff appraisals and dementia standards training have been addressed. This audit identified five areas for improvement around; implementation of the quality process, care plan interventions, activities for residents, evaluations of care and medication management.

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 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 low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. There is a documented quality and risk policy and procedure. Quality improvement plans are developed when service shortfalls are identified. Residents receive appropriate services from suitably qualified staff. An orientation programme is in place for new staff. There is an annual education and training plan that exceeds eight hours annually. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has an assessment process and residents' needs are assessed prior to entry. Assessments, care plans and evaluations are completed by the registered nurse. Residents/relatives are involved in planning and evaluating care. Risk assessment tools and monitoring forms are available and implemented and are used to assess the level of risk and support required for residents. Service delivery plans demonstrate service integration. Short term care plans are in use for changes in health status. Care plans are evaluated six monthly. The service facilitates access to other medical and non-medical services. There is a documented activity plan with activities lead by caregivers.

There is a robust medication process documented. Staff complete competency assessments.

Meals are prepared on site. Individual and special dietary needs are catered for. Residents interviewed responded favourably about the food that is provided.

Safe and appropriate environment

<p>Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.</p>		<p>Standards applicable to this service fully attained.</p>
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The building holds a current warrant of fitness. There are lounges and dining areas that allow freedom of movement. There are garden areas with accessible outdoor spaces, seating and shade including a secure area for those in the dementia unit.

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 appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. At the time of the audit there were no residents with a restraint and no residents using an enabler. Staff regularly receive training around restraint minimisation and the management of challenging behaviour.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. There have been no outbreaks since the previous audit.

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	11	0	2	3	0	0
Criteria	0	36	0	2	3	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	There is a complaints policy in place and the manager was able to explain the complaints process. There have been no complaints documented since the previous audit. Complaint forms are available at the service. Residents interviewed confirmed they received information on the complaints process on admission and the manager is very approachable should they have any concerns/complaints.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an accident/incident reporting policy to guide staff in their responsibility around open disclosure. Staff are required to record family notification when entering an incident/accident into the system. Ten incident/accident reports reviewed met this requirement (five from the dementia unit and five from the rest home). Resident files reviewed, documented family communication. Four relatives interviewed (two from the rest home and two with family members in the secure dementia unit) confirmed they are notified following a change of health status of their family member. There is an interpreter policy in place and contact details of interpreters were available.
Standard 1.2.1:	FA	Woodlands of Palmerston North provides care for up to 38 residents at rest home and secure dementia level of care. On the day of audit there were 12 rest home residents (plus three boarders) and 12 residents in the

<p>Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>dementia unit. There was one rest home resident on respite care at the time of the audit and one resident in the dementia unit funded through Manawhaikaha. All other residents were under the ARRC contract.</p> <p>The two company directors of Karaka Court Ltd operate two facilities, Woodlands of Palmerston North and Feilding. The service has a mission, business goals and quality goals that support the service goals of a family friendly service. There is an up to date business plan, a quality and risk plan and operational quality goals. Goals are followed-up through meetings and formal review.</p> <p>The service is managed by an experienced manager (non-clinical) who has been in the post for eleven years. She reports to one of the directors monthly and is supported by a clinical leader/RN who works full time Monday to Friday. The clinical leader has been in her role for four years. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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>	<p>PA Low</p>	<p>Woodlands of Palmerston North has a documented quality and risk management system. Quality and risk performance is monitored and reported through the service meetings, however not all quality data was documented as reported to meetings. Service meetings held include monthly quality and risk meetings/staff meetings and monthly resident meetings. Meeting minutes are maintained. Two annual resident and relative surveys are completed, one around meals and one general survey results communicated to residents and staff. Both of the 2019 surveys documented a high level of satisfaction with the service.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies have been reviewed at least bi-annually and include procedures around the implementation of interRAI.</p> <p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility. There are clear guidelines and templates for reporting. The facility collects, analyses and evaluates data. Action plans are developed when service shortfalls are identified and followed up until rectified. Quality and risk meetings monitor and ensure the follow-up of action plans.</p> <p>Health and safety policies are implemented and monitored by the manager. The health and safety committee meet monthly as part of the monthly quality/staff meeting. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs.</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 an electronic register. The system provides reports monthly, which are discussed at the monthly quality and risk meetings.</p> <p>Ten incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The caregivers interviewed could discuss the incident reporting process. The RN clinical lead collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. The service has reported one missing resident (safely returned to the service), to the Ministry of Health.</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>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files reviewed (the RN clinical leader, three caregivers, and one cook) included a recruitment process, which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. This is an improvement from the previous audit. Health practitioner practising certificates are maintained on file.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is a two-yearly education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. The clinical leader is interRAI trained.</p> <p>All staff who work in the dementia unit have completed the dementia standards training. This is an improvement from the previous audit.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery, meeting contractual requirements. The clinical leader (RN) and the manager (non-clinical) are on site Monday to Friday. The clinical leader is on call 24/7 when not on site.</p> <p>Caregiver rosters are as follows:</p> <p>Dementia unit: - 12 residents</p> <p>AM: two caregivers on full shifts, PM: one caregiver on a full shift and one caregiver on short shift and one caregiver on night shift.</p> <p>Rest home – 12 residents.</p> <p>AM: two caregivers on full shifts and one caregiver on short shift. PM: caregiver on long shift and one</p>

		<p>caregiver on short shift with an extra tea assist shift. There is one caregiver on night shift.</p> <p>Caregiving staff are responsible for laundry. Cleaning staff work five days a week, four hours a day. Staff reported that staffing levels and the skill mix was appropriate and safe. Residents (four) and family interviewed, advised that they felt there is sufficient staffing.</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>PA Moderate</p>	<p>The service uses robotic medication packs and an electronic charting system. Medications are checked on arrival by the clinical leader and any pharmacy errors recorded and fed back to the supplying pharmacy. Medications are stored securely. Staff sign for the administration of medications on the electronic system. There were no expired medications in the medication cupboard or in the fridge.</p> <p>The clinical leader or senior caregivers administer the medication in both areas. Annual medication competencies are completed. The clinical leader advised there were no residents self-medicating on the day of audit.</p> <p>The service has in place policies and procedures for ensuring all medicine related recording and documentation meets acceptable good practice standards. A review of ten resident medication charts evidenced that the respite resident did not have a chart (rectified on day of audit). The use of 'as needed' clonazepam did not always document the outcomes of its use.</p> <p>The medication fridge is monitored daily and the service has commenced room temperature monitoring (records sighted).</p> <p>Allergies were not documented in all 10 medication charts reviewed.</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 large workable kitchen with three cooks rostered over the week, so one is on each day. All have completed food safety training. All residents have a nutritional and hydration care requirement developed on admission, which is reviewed at the six-monthly review. Any special dietary requirements and food preferences are communicated to the kitchen and individual meals are supplied. There is a summer and winter menu. The menu rotates four weekly and is designed and reviewed by a registered dietitian (January 2018). Diets are modified as required. Kitchen fridge, food and freezer temperatures are monitored and documented. Food temperature is checked and documented prior to serving.</p> <p>There is evidence that there are additional nutritious snacks available in the unit over 24 hours for dementia residents.</p> <p>The kitchen, kitchen equipment and kitchen staff can meet the needs of the residents. There is an approved Food Control Plan which expires March 2021.</p>

		Equipment is available on an as needed requirement. Residents requiring extra assistance to eat and drink are assisted by caregivers and were observed during lunch.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Moderate	<p>Interviews with staff, residents and relatives identified that the care that is being provided is consistent with the needs of residents. Monitoring charts and behaviour monitoring charts were sighted in files sampled. Care plans did not all reflect the individualised care needs for residents.</p> <p>Residents' needs are assessed prior to admission. GP, nurse practitioner and other specialist staff input was documented as needed. During the tour of the facility it was noted that all staff treated residents with respect and dignity.</p> <p>Dressing supplies are available, and a treatment room/cupboard is stocked for use. Continence products are available and resident files included a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management.</p> <p>There were no residents with wounds. There were no pressure injuries. The clinical leader interviewed, described the assessment, plan and evaluation should there be a wound and the referral process should they require assistance from a wound specialist.</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>	PA Low	<p>The service was without an activities' person responsible for activities at the time of audit. A new activities person starts 10 March. However, activities are taken place and there is a fully trained DT onsite (but not in the role).</p> <p>The manager had documented a basic activity plan for the service in the interim time until the new activity person commences during March. During the audit, caregivers were observed providing a basic level of activities for residents in the dementia unit and for the residents in the rest home. Residents and family interviewed were happy with the current level of activities provided. Not all residents had a personalised activity plan and there was no record of activities taking place or provided since December 2019.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Moderate	<p>Care plans reviewed had been evaluated by the clinical leader six monthly, but not always when changes to care needs occurred. Six monthly evaluations were documented and included progress to meeting goals. There was documented evidence of care plans being updated as required. There is at least a three-monthly review by the GP/NP.</p> <p>There are short-term care plans to focus on acute and short-term issues and these are reviewed and signed off when resolved.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There was a current building warrant of fitness sighted, which expires on 4 April 2020. The facility is maintained in good order with regular maintenance and refurbishment. There is a comprehensive check system of the building and equipment to be carried out by the maintenance person.</p> <p>The lounge areas are designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required.</p> <p>The secure dementia unit has a separate lounge and dining area, which were both well-supervised on the day of audit. There is a secure outside/garden area.</p> <p>The external areas are well maintained and residents in both wings have access to gardens and indoor areas with ease.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Woodlands' infection control manual. Systems in place are appropriate to the size and complexity of the facility. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. Outcomes and actions are discussed at quality meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint practices are only used where it is clinically indicated, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. At the time of the audit, there were no residents with a restraint and no residents using an enabler. Staff training is in place around restraint minimisation and management of challenging behaviours.</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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The service has an implemented schedule of internal audits. Audits have been documented as undertaken with corrective action plans documented as needed. Infection control data collection is collected monthly and reviewed. The quality information around internal audits and infection control has not been consistently communicated to meetings.	Infection control data and internal audit information has not been documented as discussed in quality and risk meetings.	<p>Ensure that all quality and risk information and statistics are documented as present to and discussed at meetings.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines</p>	PA Moderate	The service has a series of robust policies and procedures, developed by an external consultant to safety guide staff around safe and effective medication	(i) One respite resident had no medication chart with staff	(i) Ensure that all resident have

<p>management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>management and administration. However, not all aspects of the policies have been adhered to including, the use of medication charts, recording of allergy status and effectiveness of 'as needed' medication.</p>	<p>administering the roll packs.</p> <p>(ii) Three of ten medication charts did not document any allergy status.</p> <p>(iii) The use of 'as needed' medication for two residents did not document the effectiveness of its use.</p>	<p>a signed medication chart.</p> <p>(ii) Ensure that medication charts record the allergy status of the resident.</p> <p>(iii) Ensure that the outcome (effectiveness) of 'as needed' medication is recorded.</p> <p>30 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 resident care plan. Not all care plans reviewed had been individualised to their specific needs.</p>	<p>One rest home resident care plan did not reflect changes to care needs following an admission to hospital including; shortness of breath, legs swelling and risks associated with insulin medication. Two dementia level resident care resident files did not reflect individualised care and support needs around behaviours that challenge.</p>	<p>Ensure that care plans reflect the individualised care needs for residents.</p> <p>60 days</p>
<p>Criterion 1.3.7.1 Activities are planned</p>	<p>PA Low</p>	<p>The service is currently without an assigned activities' person. The manager had documented a basic activity plan for the service in the interim time until the new</p>	<p>(i) There was no designated activities person at the time of</p>	<p>(i) Ensure that an activity person is</p>

<p>and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>		<p>activity person commences during March. During the audit caregivers were observed providing a basic level of activities for residents in the dementia unit and for the residents in the rest home. Residents and family interviewed were happy with the current level of activities provided. Not all residents had a personalised activity plan and there was no record of activities taking place or provided since December 2019.</p>	<p>audit.</p> <p>(ii) One resident in the dementia unit had no activities plan.</p> <p>(iii) None of the five resident files reviewed documented any activities on the activity attendance sheet or though progress notes since December 2019.</p>	<p>recruited.</p> <p>(ii) Ensure that all residents have an individualised activity plan.</p> <p>(iii) Ensure that a record of attendance is documented.</p> <p>30 days</p>
<p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>Four of five care plans reviewed all documented aspects of evaluation and changes to care when care needs changed. However, this was not always consistently undertaken. New residents have an initial care plan that should be evaluated at 21 days and updated, this had not occurred for one resident.</p>	<p>Two rest home level resident files did not document evaluations of care and changes to care plans where the care need had changed. This included one resident on return from hospital and one resident with changes to care needs as a result of skin care changes. One dementia level resident had no evaluations of care as per Woodlands policy for the initial care plan.</p>	<p>Ensure that care plans are evaluated when care needs change and according to policy and updated as needed.</p> <p>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.