Radius Residential Care Limited - Radius Peppertree Care Centre

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:	Radius Residential Care Limited
Premises audited:	Radius Peppertree Care Centre
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 11 March 2019 End date: 11 March 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: 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
	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

Radius Peppertree is owned and operated by Radius Residential Care Limited. The service provides care for up to 62 residents requiring rest home or hospital (medical/geriatric) level care. On the day of the audit, there were 57 residents.

The facility manager has been in the role five years and is responsible for the daily operations of the service. She is supported by a regional manager and a clinical manager. Residents and relatives interviewed spoke positively about the service provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant 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, relative, management, staff and the general practitioner.

This audit identified areas for improvement around interventions, medication charts and enablers.

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.

Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. There are bi-monthly resident meetings and surveys that provide residents an opportunity to provide feedback on the service.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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.

A facility manager and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme are embedded in practice. Results are shared with staff. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented and includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, 7 days a week.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Registered nurses are responsible for each stage of service provision. Initial assessments, interRAI assessments and long-term care plans were developed within the required timeframes. The residents' needs, outcomes/goals are identified, and these are reviewed with the resident and/or family/whānau input. Care plans are evaluated six monthly. The general practitioner reviews the residents at least three monthly.

Medicines are managed, and policies reflect legislative requirements. Staff responsible for the administration of medicines complete education and medicines competencies.

The activities programme provides varied options and activities that meet the abilities of each resident group. Activity plans are individualised. Community activities are encouraged, and van outings arranged.

All food is cooked on site by the chef and cook. A dietitian has reviewed the menu. All residents' nutritional needs are identified, documented and choices provided. Food and fridge temperatures are recorded.

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 has a current warrant of fitness. There is a reactive and planned maintenance programme.

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.		Some standards applicable to this service partially attained and of low risk.

The service has appropriate procedures and documents for the safe use of restraint and enablers. The restraint coordinator is the clinical manager. During the audit, four residents were using restraints and three residents were using enablers. Staff regularly receive education and training in restraint minimisation and managing challenging behaviours.

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	14	0	2	1	0	0
Criteria	0	39	0	1	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	There is a policy to guide practice, which aligns with Right 10 of the Code. The facility manager leads the investigation of non-clinical and clinical concerns/complaints in consultation with the regional manager/RN and clinical manager. All concerns and complaints are entered into an on-line complaint register. There have been three complaints and one concern since the previous audit in 2017. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. One complaint involved an HDC advocate and the complaint was investigated and resolved. Complaints forms are visible in the main entrance. Management operate an 'open door' policy. Family and residents interviewed confirmed they are aware of the complaints process and that management are approachable. The complaints procedure is provided to residents in the information pack on entry.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an	FA	There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident. Twenty-three incident forms reviewed identified that family have been notified following resident incidents. The facility manager and clinical manager advised that family are kept informed. Bi-monthly resident meetings and surveys provide residents with an opportunity to feedback on the services provided. There is access to interpreter services.

environment conducive to effective communication.		
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Radius Peppertree is certified to provide rest home, hospital level (including medical services) and residential disability -physical level care for up to 62 residents. There are 20 rest home beds, 20 dual-purpose beds (located within the 'rest home' wing) and 22 hospital level beds. On the day of audit, there were 25 rest home level and 32 hospital level residents, including 13 hospital residents in the dual-purpose beds. There were three younger persons with physical disabilities (two rest home and one hospital) contracts. There was one hospital resident under DHB Health recovery (non-weight bearing) contract. All other residents were under the ARCC. Radius has an organisational philosophy, which includes a vision and mission statement. There is a strategic business plan for April 2018 to March 2019 that has regular reviews against identified goals. Goals achieved from 2017-2018 include (but are not limited to); the implementation of an electronic resident database system, introduction of internal study days and development of RN orientation programme for oversees nurses. Quality goals include a falls reduction programme. The facility manager (previously an enrolled nurse) has been in the role five years and experienced in aged care management. A clinical manager/RN appointed in October 2018 has 30 years clinical and management experience within DHBs and aged care. The regional manager visits the service every two months and is readily available at other times and was at the service on the day of audit. The facility manager has maintained at least eight hours annually, of professional development related to managing an aged care facility including attending quarterly Radius regional meetings and Radius three day "leaders in care" conference (October 2018). The clinical manager has completed induction and infection control at the DHB since employment. Both attend the DHB aged care forums.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to	FA	Click here to enter text

consumers.		
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	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the managers (regional manager, facility manager, clinical manager/RN) and care staff, reflected staff involvement in quality and risk management processes. Resident meetings are held bi-monthly. Minutes are maintained. Annual resident and relative surveys were completed in August 2018. Results were collated and discussed with staff and residents. Results were predominantly quite satisfied or very satisfied, with 70% stating they would recommend Radius Peppertree. The service has responded to any areas for improvement and have purchased hot boxes to ensure meals reach the resident at an acceptable temperature. The service has policies and procedures and associated implementation systems, adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service's policies are reviewed at a national level by the clinical managers group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Quality data including accidents/incidents, infection control, audit outcomes are reviewed and reported to the monthly quality improvement meeting. Meeting minutes are available to all staff. Results are communicated to staff in meetings and on staff noticeboards. Corrective action plans are implemented when opportunities for improvements are identified (eg, internal audit results are lower than 95%). Corrective actions are evaluated and signed off when completed. Health and safety policies are implemented and monitored by the health and safety committee who meet three monthly and also provide a monthly report to the quality improvement meeting. The health and safety representative (maintenance person) interviewed, stated the health and safety committee have seven representatives from across the services. Health and safety representatives have completed external health and safety training. Risk management, hazard control and emergency policies and procedures are in place. The committee has reviewed the hazard register September 2018. 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. New staff and contractors receive an induction to the service including the fire evacuation procedure. As a result of data analysis completed on falls, the facility has implemented a falls reduction programme in November 2018. Falls prevention strategies include: manual handling education for all care staff, use of senor mats, analysis of falls events including times and location of falls. Exercise equipment has been purchased in consultation with staff and the physiotherapist with an appropriate programme for improving strength and balance.

		The ACC falls prevention exercise video has been introduced. Interventions are implemented on a case-by-case basis to minimise future falls.
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	Twenty-three accident/incident forms for the month of February 2019 were reviewed. There has been RN notification and clinical assessment completed in a timely manner. Accidents/incidents were recorded in the resident electronic progress notes. There is documented evidence that family/whānau had been notified. Neurological observations had been completed for unwitnessed falls and obvious knocks to the head. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered. Discussions with the facility manager and clinical manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been seven Section 31 notifications related to RN shortage describing the interim management strategies. The public health was notified of an outbreak (norovirus) in March 2018. HealthCERT and the DHB were notified of the clinical manager appointment October 2018.
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.	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files were reviewed (one clinical manager, one RN, two healthcare assistants and one maintenance/health and safety representative) that included a recruitment process (interview process, reference checking, police check), signed employment contracts, job descriptions and completed orientation programmes. Performance appraisals had been completed annually and were current in all five staff files reviewed. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. The service has experienced a turnover of RNs and while able to recruit, the management team have acknowledged the need for a more comprehensive orientation for oversees nurses who become NZ registered in order to support them working within the aged care environment. This initiative has not yet been formally evaluated. There is an implemented annual education and training plan that exceeds eight hours annually. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Staff are required to complete written core competencies during their induction. Radius Peppertree reviewed the education programme for 2018 as attendance for compulsory education was 72%. In 2018 there were two study days per year to cover the compulsory education requirements. Staff were scheduled

		to attend one of the study days. In the morning there was compulsory education for all staff including health and safety and infection control and in the afternoon sessions there are clinical sessions including wound management, skin care, pain management, medication and continence management. The clinical sessions are alternated two yearly to include all the requirements. Evaluations on the study days have been positive and there has been an increase to 93% attendance. The introduction of study days has increased staff attendance for compulsory education Registered nurses are supported to maintain their professional competency. Two out of ten registered nurses and the clinical manager have completed their interRAI training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. In the rest home/dual purpose beds (25 rest home residents and 10 hospital residents) there are two RNs on morning duty, three HCAs full morning shift and one short shift. In the afternoons there are three HCAs on the full shift and one short shift. On the night shift there is one HCA. In the hospital for up to 22 residents there is on RN on duty 24 hours. In the morning shift there are three HCAs on full morning shift and one on short shift. In the afternoons there are three HCAs on the full shift. On night shift there is one HCA. The RN in the hospital on afternoons and nights oversees the rest home/dual purpose beds. The facility manager and clinical manager are on-site Monday to Friday and available on-call. The HCAs, residents and relatives interviewed informed there are sufficient staff on duty at all times.
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.	PA Moderate	Medication policies are in line with required guidelines and legislation. Registered nurses and senior HCAs administer medications and have completed annual education and competencies. Registered nurses have completed syringe driver competencies. All medications are checked against the medication chart on delivery and any discrepancies fed back to the supplying pharmacy. All medications were within expiry dates. There were no self-medicating residents. Standing orders are not used. Medication fridge temperatures are checked daily and are within acceptable ranges. A paper-based medication charting system is used along with robotic packaging of medications. Ten medication charts were reviewed. Corresponding signing sheets were reviewed, and evidenced medications were administered as prescribed. Medication charting identified shortfalls.

Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	There is a chef or a cook and two kitchenhands (one responsible for serving tea meal) on duty each day. All baking and meals are prepared and cooked on site. There is an organisational four-week menu, which has been reviewed by a dietitian. Meals are served from a bain marie to the rest home dining room and they are delivered in hot boxes to the hospital dining room. The chef receives a dietary notification for new residents and is notified of any changes, including weight loss. Resident's likes and dislikes are known, and alternatives are offered. Each meal has daily end-cooked temperatures taken and recorded. All foods are date labelled in fridges, freezers and chiller. There is daily fridge and freezer monitoring. Staff were observed wearing appropriate protective wear and cleaning schedules are adhered to. Chemicals are stored safely when the kitchen is unattended. There is an opportunity for residents to feedback on the food service at resident meetings and through satisfaction surveys. Overall feedback from residents was positive about the food service. All food services staff have food safety qualifications with the exception of a kitchenhand who is orientating – they have received food safety education from the chef. Staff had undertaken chemical safety training. The food control plan was verified 12 July 2018.
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	When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. Residents and relatives interviewed, stated the residents' needs are being met. Significant events and communication with families are documented on the electronic documentation system (eCase). The documentation of interventions to meet the resident's needs have not been consistently documented. Adequate dressing supplies and continence products were sighted. Each wound had a wound assessment and care plan with ongoing evaluations and dressing changes at the documented frequency. There were fourteen hospital level residents with wounds, and eleven rest home residents with wounds, including six chronic ulcers. There were three stage II and one stage I pressure injuries in the hospital and one stage II and three stage I pressure injuries in the rest home on the day of audit. The GP and wound nurse specialist had been involved where applicable. Each wound had a wound assessment and care plan with ongoing evaluations and dressing changes at the documented frequency. Monitoring was evidenced for general observations, pain, blood glucose levels, change of position, fluid intake and output and weight. Specialist continence, diabetes and nutritional advice is available as needed and the registered nurses could describe this.

Standard 1.3.7: Planned Activities 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.	FA	A qualified diversional therapist (DT) who has been in the role for nine months (32.5 hours per week) is assisted by a recreational assistant (7 hours per week) to provide a programme of activity for the rest home/hospital residents Monday to Friday. The programme is planned a month in advance and is designed to meet the recreational preferences and abilities of the residents, including younger person disabled. Activities include one-on-one time, group activities, community outings and entertainment to the home weekly. There are volunteers that assist with the programme. Residents are encouraged to maintain community links. At time of audit the focus was on including more one-to-one activity. This included wheelchair walks, conversing, provision of materials to encourage individual interests and the commencement of sensory sessions. A programme of fostering animals was in place (a home for kittens had been created in one of the lounges with anticipation high as the inhabitants were to arrive shortly). The programme is displayed throughout the facility and there is a copy in each resident's room. Activity assessments, with resident/family involvement, are completed for residents on admission. The activity plan is on eCase and there is input into the resident's long-term care plan by the DT. The activity plans are reviewed three monthly. Residents have the opportunity to feedback on the programme through one-to-one communication, resident meetings and surveys. Overall resident feedback on the activity programme was good.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	RNs reviewed initial care plans within three weeks of admission and long-term care plans are developed. The long-term care plans were evaluated at least six monthly or if there is a change in health status in four of five resident files reviewed. One hospital resident had not been at the service six months. There is a three-monthly review by the GP. Relatives interviewed confirmed they are invited to participate in care plan reviews. Short-term care plans were evaluated at regular intervals with ongoing problems transferred to the long-term care plan (link 1.3.6.1).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit	FA	The building has a current building warrant of fitness that expires 5 April 2019. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All requests for maintenance and repairs are logged into the eCase system and signed off when completed. All medical and electrical equipment has been serviced and/or calibrated. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained below 45 degrees Celsius. Carpets have been replaced in the facility and new seating has been purchased for all communal lounges. The hospital nurses' station has been relocated allowing space for a dining and kitchenette area in the hospital wing.

for their purpose.		
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	Infection surveillance is an integral part of the infection control programme and is described in Radius' infection control manual. The infection control coordinator collates monthly infection data based on the standard definitions of infection. Short-term care plans are initiated for all infections. Individual resident infections are entered into the eCase system which generates a monthly infection control register form which includes signs and symptoms of infection, treatment, follow-up, review and resolution. This data is monitored and evaluated monthly and annually, and a monthly report is forward to the facility manager and provided to Radius head office. Infections are part of the key performance indicators. Outcomes, actions and trends are discussed at quality improvement meetings and staff meetings. An outbreak in March 2015 was appropriately managed. The public health unit was notified in March 2018 for a norovirus outbreak. The notification, case logs and outbreak documentation were sighted and the outbreak appropriately managed.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	PA Low	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. There were three hospital residents using bedrails as enablers and four residents (three hospital and one rest home) with restraints (bed rails and lap belts). Two residents have two restraints in place. Three resident files reviewed where an enabler was in use, identified shortfalls around enabler documentation. Staff training is in place around restraint minimisation and enablers, falls prevention and analysis and management of challenging behaviours.

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 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	A number of residents have retained their own GP and the RNs are persistently following up with the GPs to ensure all charting and prescribing meets legislative requirements (evidence	Of ten files reviewed, one (hospital) had no evidence of a medication review for over five months. Five of ten medication charts reviewed did not have indications for use on all PRN medications charted	Ensure medication charts are reviewed by the GP at least 3 monthly. Ensure PRN medication includes indications for use.

		viewed).		60 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 Moderate	Interventions in each resident's care plan are determined by their condition and assessed needs, however not all interventions were identified and documented for changes in health status.	Interventions for residents were not consistently in line with residents' condition. (i) One rest home YPD resident had a significant medical event resulting in changes to their ability and needs. Nil changes had been made to the current care plan or a STCP commenced in the intervening four months. A weight loss of 4.5kg had occurred in this time, there were no interventions documented to manage this. (ii) An insulin dependent rest home resident had no diabetes management plan. Interventions were listed for action should the blood glucose level go either side of the desired range, but there was nil documented in care plan – or referred to information to alert staff to when the resident may become hyper or hypoglycaemic. (iii) No assessment or interim care plan informing staff of required interventions was completed within a week of admission for a hospital resident admitted on a Healthcare Recovery (non-weightbearing) contract.	Ensure interventions reflect the residents assessed needs/risks. 60 days
Criterion 2.1.1.4 The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.	PA Low	One of three resident files reviewed did not evidence voluntary consent for enabler use. Enabler use had not been identified in the two of three care plans reviewed.	(i) Two residents had not given voluntary consent for enabler use and (ii) the use of enabler had not been linked to the care plans for two resident files reviewed.	(i) Ensure voluntary consent is obtained and documented and (ii) ensure enabler use is linked to the care plans. 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.