Amberley Resthome 2013 Limited - Amberley Resthome and Retirement Village

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 The DAA Group 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:	Amberley Resthome 2013 Limited
Premises audited:	Amberley Resthome and Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 14 May 2019 End date: 14 May 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: 20

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

Amberley Rest Home provides rest home level care for up to 21 residents. The service is privately owned and managed by the owner/operator and a clinical manager. A provisional audit was undertaken earlier in 2019; however, the sale did not go through and the facility is no longer on the market. Positive comments about the high level of care and support from staff were provided during the audit.

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

This audit has identified two areas requiring improvement relating to short term care planning and medicine 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.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required.

Information on how to make a complaint is readily available. A complaints register is maintained and verified that complaints are investigated and resolved promptly and effectively.

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 strategic business plan describes the values and mission of the service and includes short and long-term goals. A separate quality and risk management plan is implemented. The owner/operator provides ongoing reports to the co-owner and specialist input is accessed to assist with ongoing monitoring of the services. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented as required. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures that are reviewed regularly support service delivery and were current.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery. Regular individual staff performance reviews are occurring.

Staffing levels and skill mix meet the changing needs of residents.

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.

The multidisciplinary team, including registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Changes are made to care plans as clinically indicated.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community. Individual resident's activity plans reflected a personalised approach.

An electronic system enables medications to be safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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 on public display.

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 organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers or restraints in use at the time of the audit. Staff attend annual training about managing behaviours that challenge and use of enablers and restraint to ensure they remain updated.

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 prevention and control programme is led by a registered nurse/trained infection control coordinator. Annual reviews of the programme are occurring. Specialist infection prevention and control advice is accessed when needed.

Aged care specific infection surveillance is undertaken, and results are discussed with staff. Any required follow-up action is identified and instituted when required.

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	0	2	0	0
Criteria	0	37	0	0	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 and concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and copies of the form, advocacy service information and a complaints/suggestion box are available at the front entrance. Family members interviewed, and all except one resident interviewed, knew how to make a complaint. A recent visit from the advocacy service provided an opportunity to update residents and staff about the Code. The complaints register is in an electronic format with associated hard copy complaint forms and correspondence records in a complaints folder. Records were complete for all complaints received in the sample that were individually checked. Appropriate actions have been taken through to an agreed resolution, all are documented, and responses have been completed within the required timeframes. Action plans showed any required follow up and improvements have been made where possible. The manager (owner/operator) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.9: Communication Service providers	FA	Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents interviewed stated they were kept well informed about any changes to their status. Adverse event forms and complaint documentation demonstrated family members are advised in a timely manner about any incidents or accidents.

communicate effectively with consumers and provide an environment conducive to effective communication.		Communication records in residents' files confirmed family members are advised of any change in their relative's condition. The manager was aware of how to access interpreter services, although reported this has not yet been required as all residents have been fluent in English. Policy documentation described how to access various types of interpreter services, including for people with impairments that affect communication. Communication process for a person who is visually impaired are respectful of their needs and abilities.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The strategic business plan 2018 – 2020 was last reviewed August 2018. This provides an overview of the industry and of the Amberley Rest Home. It includes a philosophy statement, which in summary describes the intention to promote a quality lifestyle for residents in a safe, supportive environment, for residents to be treated with patience, dignity and respect and states they will be encouraged to be independent. A Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis has been undertaken and annual and longer-term business and operational objectives, plus associated operational strategies, are described. The owner/operator (manager) shares ownership with a partner and stated that this means much of the reporting is informal. However, more formal reporting was evident with a quality and risk management consultancy, a legal support team and accountants. These relationships are ensuring accountability with ongoing monitoring, including for risk management occurring. The owner/operator, otherwise referred to as the manager, is suitably experienced and has been in the role for five years. Responsibilities and accountabilities are defined in a job description. Previous experience included seven years in an administration role for another aged care facility and retirement village. During this time the village manager mentored the current owner/operator at Amberley Rest Home, which supported their personal and professional development. The use of other professionals, attendance at internal and external education opportunities and ongoing liaison with the DHB portfolio manager is enabling the manager to develop new skills and to remain updated on knowledge of the sector, regulatory and reporting requirements. A performance appraisal for the manager is completed with the quality consultant every two years. The service holds a contract with the district health board (DHB) to provide rest home level care. Of the 21 available beds, 12 of these are studio units that are occupied under Occupation Right Agreements (ORAs) and are along the corridor from the main rest home area. There are nine other rooms designated for rest home level care residents. On the day of audit one of the studio units was empty and one other was occupied by a fully independent person. Three people in the facility are private paying.
Standard 1.2.3: Quality And Risk	FA	A quality consultant is contracted to assist and support Amberley Rest Home management and staff to implement their quality and risk management system. The planned system reflects the principles of quality assurance and continuous quality improvement and includes management of incidents and complaints, internal audit activities,

Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		regular reviews of residents' satisfaction, monitoring of outcomes, health and safety, risk management, clinical incidents including infections and any restraint use, for example. Meeting minutes reviewed confirmed regular review and analysis of the associated quality indicators and that related information is reported and discussed at the quality and risk team meetings and at staff meetings. Staff reported their involvement in quality and risk management activities through infection control and incident reports, reading meeting minutes and ensuring they complete tasks as per the instructions and expectations of the manager and the registered nurse. An internal audit schedule is in use and the audits are occurring within the expected timeframes. Corrective actions and quality improvements are developed across the quality and risk review systems and are implemented accordingly. Resident and family satisfaction surveys are completed annually. The most recent survey raised some comments around communication with senior staff and these issues have since been addressed. Policies and procedures are developed in consultation with the contracted quality consultant who also manages the document control processes. The documents reviewed during the surveillance audit were applicable for the purpose, all were current, and all were based on best practice. The document control system is ensuring a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents is occurring. The manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. A risk management policy included a plan that identifies the various risks under the categories of health and safety, service delivery and financial according to their potential impact. Policies and procedures reflected the Health and Safety at Work Act (2015) and the updated requirements are being implemented. Ongoing monitoring is occurring according to the risk management plan and outcomes are reported through the quality assurance programme.
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	FA	The manager described the incident reporting process, although noted that the registered nurse, who was unavailable for this audit, follows up most of the incidents. Staff document adverse and near miss events on an accident/incident form. The information is entered electronically into a database in preparation for follow-up and review. A sample of entries related to a range of incidents were reviewed and showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported through the quality and risk management system and discussions on issues raised occur at the staff and quality and risk meetings. Corrective actions and quality improvements initiatives are implemented when indicated. The manager described essential notification reporting requirements. There have been no such notifications of significant events made to the Ministry of Health, or any other significant authority since the provisional audit in February 2019. Documentation around the one notification since the previous certification audit, was reviewed and

their family/whānau of choice in an open manner.		noted in the provisional audit report.
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	Policy documents related to human resources management and processes are based on good employment practice and relevant legislation. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. Staff files overall include completed formal application forms, interview records, evidence of police vetting and that the registered nurse has a current practising certificate. There was evidence of checks made for practising certificates of GPs and the podiatrist, for example. The residents in the studio units under ORAs receive their care and support from the same staff as the other residents in the facility. Staff orientation records in staff files confirmed all necessary components relevant to the role are worked through and signed off. During interview, staff reported that the orientation process is under review with efforts now being made to use the same senior caregiver throughout as much of a person's orientation as possible. Observations made of a new staff person during their first shift of being buddied were positive. The manager informed she regularly checks in with new staff. A list of core training topics has been developed and a schedule of training dates developed each year. A copy of the 2018 staff training schedule and the plans thus far for 2019 were sighted. Most care staff have either completed level three or level four of a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Other staff have commenced the training. The registered nurse, who is an internal assessor of the staff training programme, is also competent in undertaking interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. If a person does not attend a mandatory internal training requirement then they are required to complete a self-learning package. Evidence of this occurring was sighted.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is available in relation to what determines staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). This sits alongside a roster framework that is based on guidelines from the DHB. Although seldom necessary, the manager described examples of how the facility has adjusted staffing levels to meet the changing needs of residents. The registered nurse is on call 24 hours a day, seven days a week (24/7) with assistance from registered nurses at the local 24/7 medical centre, when she is unavailable. The manager attends to non-clinical call out issues. Staff informed during interview that they feel well supported, there are sufficient numbers of staff for each duty and that they only need to go to the manager if they need extra help. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided as per the roster framework. Staff had been replaced by the rest home's own casual pool staff for unplanned absences and

		annual leave. Studio units under ORAs are integrated into the facility, therefore staff attend to the rest home level care residents under the ARRC agreement as they do those in the designated rest home rooms. Staff work in all areas of the facility and provide the same level of care to all residents. Hands-on staff members are required to have a first aid certificate, therefore there is always at least one staff member on duty who has a current first aid certificate. Staff with first aid certificates are identifiable on the rosters, as was the person responsible for medicine administration on each duty.
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	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. This was verified by review of staff records, observation and staff interviews. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. Medicines are stored in a locked trolley in a locked room when not in use. It was noted at the time of audit not all medications sighted were within current use by dates. A clinical pharmacist is available for advice as needed. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided a record of accurate entries; however, six monthly physical stock checks are not occurring, and weekly checks are not occurring consistently. The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. A review of ten medication records identified good prescribing practices including the prescriber's identity and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review was consistently recorded on the medicine record. All medication records reviewed had a photograph of the resident used to assist with identification. Photographs are reviewed to ensure the likeness remains current. There were no residents self-administering medications at the time of audit. There is an implemented process for reporting and analysis of medication errors.
Standard 1.3.13: Nutrition, Safe Food,	FA	The food service is provided on site by a cook and the menu is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and a review of the menu by a qualified dietitian was

And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.		underway at the time of the audit; this review was last completed in March 2017 with updates to the winter menu in July 2018. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Hurunui District Council, expiry date 28 February 2020. Food temperatures, including for high risk items, are monitored appropriately and recorded daily as part of the plan. Fridge and freezer recordings are observed daily, were sighted and meet food safety requirements. All food stored identified expiry dates including opened and decanted items. Practices for decanting food stuffs were observed and meet food safety guidelines. Kitchen staff interviewed had a good understanding of food safety management and had undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available. All meals are cooked and served directly from the kitchen at the time of the meal. The kitchen is available to staff to provide residents with food, drinks and nutritional snacks 24 hours a day. Residents and family members interviewed were happy with meals. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Documentation, observations and interviews verified the care provided to residents was consistent with their assessed needs, goals and the documented plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. Family interviewed reported the staff knew their relative well. However, not all residents assessed short term needs were documented in care plans therefore required interventions and desired outcomes to ensure appropriate service delivery were unclear. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is appropriate. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity	FA	The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy. The programme is available twenty hours per week. A personal profile which includes a social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. The information obtained is reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated on admission and an individual activities plan is formulated, this includes the provision of group and one to one

requirements are appropriate to their needs, age, culture, and the setting of the service.		activities as appropriate to meet the individual resident's needs. The level of each resident's participation in the activities programme is monitored and each resident's progress towards personal activity goals is evaluated as part of the formal six monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples of activities in the programme included exercise and balance classes, table bowls, housie, shopping trips and outings. Residents and families/whānau are involved in evaluating and improving the programme through residents' meeting and individual reviews. Residents interviewed confirmed they find the programme varied, interesting and includes outings to places of interest and local events.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. Progress notes sighted were comprehensive and informative. If any change is noted, it is documented and reported to the registered nurse who is on call when not present at the facility. Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. All evaluations are recorded by the registered nurse. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of long term care plans being reviewed and progress evaluated as clinically indicated were noted. Wound management plans are being reviewed according to the individual treatment plan with evaluation occurring when dressings are changed. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes. The diversional therapist evaluates activities plans against the resident's goals six monthly and plans are updated as the resident's assessed needs change.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expiry date 14 October 2019) is publicly displayed at the front entrance. There have been no modifications to the building since the last audit.

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	Procedures to follow for the surveillance of infections are described within the infection prevention and control policy and procedures manual. These are consistent with the expectations for long term care facilities. The registered nurse/infection prevention and control coordinator reviews all infections that are reported by caregivers and these are documented on an infection incident form. New infections and any required management plan are discussed at handover. Monthly surveillance data is collated, entered into an electronic system and the data analysed to identify any trends, possible causative factors and required actions. As per the quality consultant's electronic system, graphs are produced that identify trends for the current year, and comparisons against previous years are made. Data is benchmarked externally with other aged care providers, which has provided assurance that infection rates in the facility are below average for the sector. Meeting minutes confirmed that results of the surveillance programme are shared at the monthly quality and risk management meetings, via regular staff meetings and at staff handovers. During interviews, staff described their responsibilities around reporting any suspected infection. They spoke of strategies for the prevention of the spread of infections, including isolation procedures. Staff also described attendance at education sessions about infection prevention, their involvement in demonstrating good handwashing techniques and confirmed that the registered nurse discusses infection numbers and ways to control the numbers at staff meetings and/or staff handovers.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation and safe practice policies and procedures that include relevant definitions and meet the requirements of the standards are available to provide guidance on the safe use of both restraints and enablers. These confirmed the voluntary nature of enablers. The manager informed the registered nurse is responsible for the oversight of any restraint or enabler use should it be required. A restraint register has been set up; however, there has been no use of any restraint or enabler since the last audit. Confirmation of this was evident in quality and staff meeting minutes where it is an agenda item. Staff confirmed their attendance at internal education on restraints and enablers and on the management of people with behaviours that challenge. Records sighted showed the last training on these topics was October 2018.

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 1.3.12.1 A medicines 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	PA Moderate	The facility has a documented medication management system to manage the safe and appropriate prescribing, dispensing, review, storage, disposal and reconciliation in order to comply with legislation, protocols and guidelines. When interviewed, the medication competent carer could identify the correct procedure for labelling and storage of medication. At the time of audit five examples of out of date medications were found. Examples sighted included stock items and medications individually prescribed to residents. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided a record of accurate entries; however, six monthly physical stock checks are not occurring, and weekly checks are not occurring consistently. At the time of audit three examples of weekly stock checks being missed were sighted. This was verified by interviews with staff and review of records.	Storage of medications is appropriate; however, there is no process in place to ensure expired medications are disposed of in a timely manner. A weekly stock count of controlled drug is not always completed, and six monthly physical pharmacy stock takes of controlled drugs do not occur, as required by legislation.	A process is required to ensure expired medications are disposed of in a timely manner. Weekly stock checks of controlled drugs consistently occur and six monthly physical stock checks of controlled drugs are completed.

guidelines.				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 Moderate	Residents' long term care plans reviewed were based on assessed needs, were comprehensive and detailed interventions were documented to meet desired outcomes. Care provided for identified short term needs was documented in detailed progress notes. However, not all reviewed residents' identified short term needs were documented in care plans therefore required interventions to ensure appropriate service delivery to meet desired outcomes were unclear. In resident files reviewed examples included a resident with short term needs following a minor surgical procedure, a resident who was unwell and a resident with an identified infection whose short term needs and care interventions were not documented. Telephone interview with the registered nurse confirmed short term care plans are not consistently documented.	Of the files reviewed, records showed the desired outcomes and required interventions to meet short term needs were not consistently documented.	Provide evidence short term care planning is occurring in a timely manner including the documentation of desired outcomes and required interventions to meet residents' assessed short term needs. 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.