

The Napier District Masonic Trust

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:	The Napier District Masonic Trust	
Premises audited:	Taradale Masonic Residential Home & Hospital	
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 21 January 2015	End date: 22 January 2015
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:	66	

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

Masonic Residential Home & Hospital provides residential care for up to 68 residents. On the day of audit there were 66 residents.

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. This 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 is operated by a Board of Trustees, who oversees the governance of the home. There are strategic plans and a documented quality and risk plan which is monitored by the board and management team. The facility is managed by a facility manager, who also takes the role of the quality manager. The clinical leader is a registered nurse, with current practising certificate and experience in aged care. The manager has maintained eight hours of professional development relating the management of an aged care facility. Family and residents interviewed all spoke positively about the care and support provided.

Eleven of twelve shortfalls from the previous audit around, admission agreements, resuscitation consent, care plan interventions, the assessment process, six monthly evaluations, medication management chemical storage and fire evacuation have been addressed. There is still an improvement required around signing for medications. This audit identified further improvements required around incident forms and care plan documentation.

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.

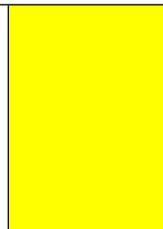


Standards applicable to this service fully attained.

There is an open disclosure policy which describes ways that information is provided to residents and families. Regular contact has been maintained with family including if an incident or care/ health issues arises. Document review confirms that open disclosure principles were implemented. Complaints processes were known by the staff, residents and families and the complaint register was up to date.

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

The service continues to implement a quality and risk management system. An annual resident and/or relative satisfaction survey has been completed. Adverse event reporting occurs and staff communicate events to relatives where appropriate. There are established human resources policies and procedures in place. New staff have been provided with a comprehensive orientation programme. There is an in-service training programme covering relevant aspects of care and support. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are appropriate for the level of service provided.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
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Assessments, care plans and evaluations have been completed by the registered nurses. Risk assessment tools and monitoring forms are available and implemented. Care plans reviewed were individualised. Care plans have been evaluated six monthly or more frequently when clinically indicated. Activities are planned to meet the needs of the resident. Sufficient activities and outings have been provided. An appropriate medication management system is in place. Food is prepared on site by the main kitchen. Residents with special dietary needs have these needs reviewed as part of the six monthly care planning review process. Residents interviewed confirmed satisfaction with food services.

Required corrective actions from the previous audit around care plan and assessment documentation have been addressed.

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.
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The building holds a current warrant of fitness which expires on 1st Nov 2015. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. Hot water temperature is monitored in resident areas and was within the acceptable range.

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 one resident with an enabler in the rest home and seven residents with restraint in the hospital. Policies and procedures are in place to guide staff and encourage a restraint free environment. Education has been provided as part of the annual training schedule.

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 infection control programme is appropriate for the size and complexity of the service. Infection control data has been collated monthly. Results of data analysis are communicated to staff. Action is taken to reduce the infection rates according to surveillance results and any issues of urgency are dealt with 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	20	0	2	1	0	0
Criteria	0	45	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The previous audit evidenced that the process for documenting resuscitation status was inconsistent. Six resident files reviewed for this audit all have resuscitation status documented and signed as per the policy. This is an improvement on the previous audit.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	The previous audit evidenced that complainants were not always informed regarding advocacy by the service. Three complaints reviewed for this audit all had advocacy information documented. This is an improvement on the previous audit.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Residents and family interviewed confirm awareness of the complaints processes and availability of the complaints form. Information is located throughout the facility to allow complaints to be made and recorded. A complaints policy that meets the health and disability code is recorded. A complaints procedure is provided to residents within the information pack at entry and displayed at the facility. Three complaints for the year 2014 reviewed. All complaints had been addressed within

		required timelines and all were recorded on the complaints log.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There are policies and procedures in place around open disclosure, incidents and accidents and complaints. Care plans documented that the resident and family, where appropriate, and have been consulted with care plans.</p> <p>Twenty one resident related incident forms for November all document that family have been informed. One form documents that the resident requested that family should not informed.</p> <p>Residents interviewed state staff and management communicate well with them. Family member interviewed also stated communications are thorough and that they are informed of changes in health status. Interpreter services are available.</p> <p>Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – “what you need to know” is provided to residents on entry.</p> <p>The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. Six agreements were reviewed and this was clearly communicated in each agreement. All admission agreements are signed by the resident or an EPOA this is an improvement on the previous audit.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The service provides residential care for up to 68 residents. On the day of audit there were 29 residents at hospital level and 37 at rest home level.</p> <p>Taradale Masonic Residential Home & Hospital is operated by a Board of Trustees, who oversees the governance of the home. The Board meet monthly. The Board receives briefings from the managers at their meetings. There are strategic plans and a documented quality and risk plan which is monitored by the board and management team. Business property development s and quality objectives are clearly stated in the plans. Falls prevention and a restorative approach to care and support are included in the plan and evidenced through care plans.</p> <p>The site is managed by a facility manager, who also takes the role of the quality manager. The clinical leader is a registered nurse, with current practising certificate and experience in aged care. The Manager has maintained eight hours of professional development relating the management of an aged care facility.</p>

<p>Standard 1.2.2: Service Management</p> <p>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 consumers.</p>		<p>The Manager holds a Masters in Quality Systems and has worked for the home since April 2011; she has held the management role since August 2012. The Clinical Manager has 23 years' experience as a registered nurse and has worked at the home for 13 years. The Clinical Manager is designated to manage in the absence of the manager.</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>FA</p>	<p>The quality and risk management process and plan continues to be implemented. The plan has been reviewed regularly and updates made to the board on progress.</p> <p>The organisation's manuals include policies and procedures that cover a broad range of clinical and management topics. These have been updated regularly if a need arises and at least every two years. Any new policies or policy changes are communicated through staff meetings and the management meeting and communicated to staff through staff meetings. Two registered nurses and four caregivers interviewed confirmed a working knowledge of policies.</p> <p>Key components of the quality system and monitoring of quality are communicated through a series of meetings such as the monthly quality and management meetings, health and safety meetings, infection control meetings and monthly reports to the board. Meeting minutes reviewed all included quality outcomes and action plans as needed. Trends are analysed through collection and collation of data, examples noted were falls and infection control data.</p> <p>An internal audit programme is implemented for a wide range of operational areas. Action plans were documented and implemented where necessary and communicated to staff through meetings. Thorough projects are in place where an issue poses risks.</p> <p>There is a health and safety, and risk management programme being implemented. There is a safety representative who has attended training. There is a current hazard register.</p> <p>The emergency management action plan amendments following a building extension were sighted and provide a good example of preventive and corrective action operation.</p> <p>D19.2g Fall prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. The manager described a focus on improved falls management with supporting policy, guidelines, follow-up and KPI monitoring. Good Vitamin D</p>

		prescribing levels. The manager is a member of the HBDHB Falls Steering Group.
<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>	PA Low	<p>Incident and accidents are collected on the prescribed form. Forms reviewed had been completed comprehensively, reviewed by the clinical manager, health and safety team and manager and signed off. Monthly analysis of incidents by type is undertaken by the service, reported onto run charts and reported to quality meeting and senior management. The manager is aware of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>A review of resident progress notes evidenced that not all incidents were routinely reported, this includes bruises and pressure sores.</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>Policies and procedures are in place to guide recruitment practices and there are documented job descriptions for all positions.</p> <p>Five staff files reviewed all documented appropriate recruitment documentation (three caregivers who work across the service areas and two registered nurses).</p> <p>A register of practising certificates is in place. Performance appraisals are current in all files reviewed. Interview with four caregivers and two registered nurses inform management are supportive and responsive. An annual training plan is being implemented and registered nurses are supported to maintain their professional competency.</p> <p>The facility employs a nurse educator, who plans and implements a training schedule that includes mandatory training for all staff. The calendar is on display in staff areas. Staff must attend training and are followed up to ensure all mandatory training has been received in the course of the year. Care givers are studying ACE Aged Care modules. A record of staff progress in achieving the modules is maintained by the nurse educator.</p> <p>All staff employed by the facility to care for residents hold a clinical qualification or are studying towards their ACE qualifications.</p> <p>There was a comprehensive orientation programme being implemented with completion of prescribed modules being completed by new employees.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or</p>	FA	<p>Taradale Masonic employs a clinical manager, a registered nurse coordinator (day to day clinical management) and a nurse educator; there is a registered nurse on duty every shift plus enrolled nurses on duty. There is a dedicated InterRAI assessment registered nurse. Caregivers are rostered for all areas and all shifts. The service also</p>

experienced service providers.		provides bed making staff housekeeping, laundry, and DT, kitchen and maintenance staff. Staffing is comprehensive and fully meets the need of the residents.
<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>	PA Low	<p>Policies and procedures are in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit and both had an assessment and consent with three monthly reviews. There is a medication room for rest home and one for the hospital. All medications were securely and appropriately stored. Registered nurses or senior caregivers/ enrolled nurses administer medications who have passed their competency administer medications. Medication competencies were updated annually and general medication administration and syringe drivers. Medication charts have photo ID's.</p> <p>There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. All 12 medication charts reviewed have as needed medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges.</p> <p>Since the previous audit the service has made improvements around documentation of as needed medications, medication storage, resident self-administration of medication and three monthly GP reviews.</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>	FA	<p>The service continues to provide a high level of meal service to the residents. Five residents and one relative interviewed all praised the meals. There is a well-equipped, clean kitchen with a main cook and relief cook employed; both have been trained in food handling. There is a kitchen manual, a cleaning schedule and regular audit of kitchen services.</p> <p>Food preferences and special diets are catered for. Resident's dietary needs are included as part of the on-going assessment process and all information is communicated to the kitchen.</p> <p>Meals are usually transported to the two dining rooms, on the day of audit the service was 'bug spraying' so services had been re-arranged. However it was evident that the staff take the time to ensure that all residents have hot meals and provide assistance as needed.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The previous audit found that the initial care plan/ assessment conducted on admission to the facility did not cover cultural aspects of residents' needs. The service has now reviewed all care plans and all care plans, including the initial care plan and all include cultural needs.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The service uses the interRAI assessment process and care plans reviewed reflected the needs as identified by the interRAI assessment process. This is an improvement on the previous audit (link 1.3.6.1).</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>Interview with the GP evidenced that care provided is of a high standard and the GP is kept informed. Five residents and one family member agreed that the care is good and that they were involved in the care planning. Caregivers (four) and RNs (two) interviewed stated there is adequate equipment provided including continence and wound care supplies.</p> <p>Wound assessment, wound management plans and evaluations are in place for 15 residents (eight hospital, and seven rest home). There were three residents with pressure areas. Access to specialist advice and support is available as needed and is documented as occurring. Care plans document allied health input. Shortfalls were identified around documentation.</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>	<p>FA</p>	<p>There are two activities staff at the facility, one for rest home residents and one for hospital. Residents and staff interviews confirmed the activities programme included input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.</p> <p>Improvements to the activity programme as a result of resident feedback have been made.</p> <p>All five residents' files document included an individualised activities care plan with longer term resident plans reviewed at least six monthly</p> <p>Interview with the staff confirms the activities programme meets the needs of the service group and the service has appropriate equipment.</p> <p>D16.5d Resident files reviewed identified that the individual activity plan is reviewed at least six monthly.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans were evaluated by the registered nurse six monthly in long term resident files sampled. This is an improvement on the previous audit, (two residents had not been at the service long enough for a review). Short term care plans for short term needs were evaluated and either resolved or added to the long term care plan as an on-going problem. There was at least a three monthly review by the medical practitioner. The family member interviewed confirmed they were invited to view care plans.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>The previous audit noted that chemicals were not always appropriately labelled and stored. Since the previous audit the service has adopted the services of a National chemical provider. All chemicals were secure and labelled.</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>	<p>FA</p>	<p>The building holds a current warrant of fitness which expires on 1st Nov 2015. Fire equipment is checked by an external provider. Electrical equipment has been tested and tagged. Reactive and preventative maintenance occurs. Hot water temperatures are monitored in resident areas and are within the acceptable range. The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents are observed moving freely around the areas with mobility aids where required. The external areas and gardens are well maintained. There are outdoor areas with seating and shade. There is wheelchair access to all areas. Since the previous audit the service has sealed and upgraded shower seats. Carpets have been made safe and are scheduled for replacement as part of the service strategic plan.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>The previous audit found that the fire evacuation schedule for a new wing needs to be approved. This is now in place (2nd October 2013). Fire evacuations are four times a year with the last practice 6th December.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The service has one resident with an enabler on the rest home and seven residents with restraint in the hospital. Policies and procedures are in place to guide staff and encourage a restraint free environment. Education is provided as part of the annual training schedule.</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>	<p>FA</p>	<p>A robust infection control surveillance programme continues. Surveillance procedure is described in the infection control manual. Surveillance reporting is a standard part of the information considered at quality meetings. The board is kept informed if there are any issues and receive summary data monthly. The surveillance programme is suitable for an organisation of this type.</p> <p>Data is collected throughout the month, this is presented to the Quality Committee who then evaluate and make decisions if any are required. Graphs are also prepared for trend analysis.</p>
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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 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>The service collects a wide range of incidents and collated all incidents monthly. Run charts are developed and results and trends are used to improve services. This is particularly well developed with fall prevention. All falls are reviewed by the service restorative meeting which includes a physio therapist.</p>	<p>A review of resident progress notes and wound charts evidences that bruises and pressure sores were not routinely recorded on incident forms.</p>	<p>Ensure that all incidents are reported through incident forms</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	<p>All five care plans reviewed reflected the InterRAI assessment. Care plans were individualised, interviews with staff reflect that staff have a good knowledge of resident personal likes and dislikes.</p> <p>Progress notes are in the form of daily flow charts and staff sign each shift that they have achieved all</p>	<p>(i) One hospital file had weight loss documented in progress notes and one a bruise. RN follow up was not documented. (ii) One hospital resident file had instructions for apex beat monitoring this has not been documented as occurring. (iii) Care plans do not document the care required as documented in progress</p>	<p>(i) Ensure documentation reflects follow up occurs, (ii) Ensure that care plans document the care and support needed, (iv) Ensure that wound care plans have one plan per wound and document a clear review/ evaluation.</p>

		resident care documented as part of the progress notes flow chart process.	notes for example; toileting, signs of infection and use of a sensor mat. (iv) Wound care plan documentation evidenced that there is more than one wound per care plan for residents with multiple wounds, (v) not all wounds have a short term care plan in place, (vi) wound evaluations are not always documented. (vii) For residents with restraint, the long term care plan does not include interventions and risks associated with restraint in three files. In all cases staff interviewed were aware of the care and support needed and residents stated they were well cared for.	60 days
<p>Criterion 1.3.12.1</p> <p>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 guidelines.</p>	PA Low	<p>Policies and procedures are in place for all aspects of medication management, including self-administration. There were two residents self-administering on the day of audit and both had an assessment and consent with three monthly reviews. There is a medication room for rest home and one for the hospital. All medications were securely and appropriately stored. Registered nurses or senior caregivers/ enrolled nurses administer medications who have passed their competency administer medications. Medication competencies were updated annually and general medication administration and syringe drivers. Medication charts have photo ID's.</p>	<p>The controlled drug medication book has one instance of only one signature, controlled drug administration in the rest home and hospital had instances of only one signature on the medication signing sheet. (Practice changed on day of audit). There was one instance of regular non packaged medication not signed for and two instances of as needed medication having no signature or time.</p>	<p>Ensure that medications are signed for according to policy.</p> <p>60 days</p>

		<p>There is a signed agreement with the pharmacy. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There is a list of standing order medications that have been approved by the GP's. Staff sign for the administration of medications on medication sheets held with the medicines. Medication profiles are legible, up to date and reviewed at least three monthly by the G.P. All 12 medication charts reviewed have as needed medications prescribed with an individualised indication for use. The medication fridge has temperatures recorded daily and these are within acceptable ranges.</p> <p>Since the previous audit the service has made improvements around documentation of as needed medications, medication storage, resident self-administration of medication and three monthly GP reviews.</p>		
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.