# Charles Fleming Retirement Village Limited

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Charles Fleming Retirement Village Limited

**Premises audited:** Charles Fleming Retirement Village

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 16 November 2015 End date: 17 November 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:** 107

# 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** |
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|  | 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 |
|  | 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

Charles Fleming Retirement Village is a Ryman Healthcare facility. The facility provides rest home, hospital level and dementia level of care for up to 120 residents in the care centre and up to 20 rest home residents in the serviced apartments. On the day of audit, there were 107 residents (including seven in serviced apartments). The village manager is suitably qualified and supported by a clinical manager (registered nurse) and an assistant village manager. There are systems in place that are structured to provide appropriate care for residents. Implementation is being supported through the Ryman Accreditation Programme.

The audit was conducted against the relevant Health and Disability standards and the contract with the District Health Board. The audit process included a review of policies and procedures; the review of resident’s and staff files, observations and interviews with family, residents, staff and management.

The five shortfalls from their previous certification around incident/accident reporting, staffing, consumer records, documented interventions, medication checks on delivery and transcribing have been addressed.

This audit identifies improvements are required around InterRAI assessments for new admissions and indications for use of ‘as required’ medications.

## Consumer rights

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| 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. |

Communication with residents and families is appropriately managed and documented. The complaints process is provided to residents and families as part of the admission process. A complaints register is in place that includes all complaints, dates and actions taken. Complaints are being managed in an appropriate manner and meet the requirements set forth by the Health and Disability Commissioner.

## Organisational management

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| 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. |

Ryman Charles Fleming continues to implement the Ryman Accreditation Programme that provides the framework for quality and risk management and the provision of clinical care. The service has policies and procedures to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Key components of the quality and risk management system include monitoring all adverse events. Data that is collected is analysed and evaluated.

The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. There is an annual education schedule that is being implemented. In addition, opportunistic education is provided. Aged Care Education is in place for the caregivers. The facility is adequately staffed. Registered nursing cover is provided 24 hours a day, seven days a week.

## Continuum of service delivery

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| 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 low risk. |

Initial assessments and risk assessment tools are completed by the registered nurse on admission. Care plans and evaluations reviewed were completed by the registered nurses within the required timeframes. Care plans demonstrated service integration, were individualised and evaluated six monthly. The residents and family interviewed confirmed they were involved in the care planning process. Residents are reviewed at least three monthly review by the general practitioner.

The activity coordinators and diversional therapists provide separate activities programme for rest home, hospital and dementia care residents. The Engage programme ensures the individual abilities and recreational needs of the resident are met. The programme is varied, interesting and involves the families and community.

There were policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The GP reviews medication charts at least three monthly.

Meals are prepared on site. The menu has been designed by a dietitian at organisational level. Individual and special dietary needs were catered for. Alternative are provided. There are additional snacks available 24 hours in the dementia units.

## Safe and appropriate environment

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| 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 certificate for public use.

## Restraint minimisation and safe practice

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| 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. |

There were comprehensive policies and procedures that meet the restraint standards. There is a restraint coordinator with delegated responsibilities. Enabler and/or restraint use is discussed at quality and clinical meetings. There was ongoing restraint and challenging behaviour education evident. There were no residents requiring enablers and seven residents with restraint usage at the time of audit.

## Infection prevention and control

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| 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 includes policies and procedures to guide staff. A registered nurse is the infection prevention and control officer. A monthly infection control report is completed and forwarded to head office for analysis and benchmarking. A six monthly comparative summary is completed. Surveillance data is used to determine infection control activities and education needs at the facility. The service has had one outbreak since the previous audit.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **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 | 15 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 39 | 0 | 2 | 0 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints procedure is provided to residents and relatives at entry to the service. The village manager has the overall responsibility for ensuring all complaints (verbal or written) are fully documented and thoroughly investigated. The number of complaints received each month is reported to staff via the various meetings. A complaints register has been maintained that includes relevant information regarding the complaint. Discussion with six residents (three rest home and three hospital) and one relative confirmed they were provided with information on the complaints process. Complaints information is provided on admission.  Eight complaints were received in 2015 (year to date) with evidence of appropriate and timely follow-up actions taken. Documentation including follow-up letters and resolution demonstrates that complaints were well-managed. All of the complaints received in 2015 are resolved, including two complaints lodged in 2015 through the Health and Disability Commissioner. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is an incident reporting policy, and reporting forms that guide staff around their responsibility to notify family of any resident accident/incident that occurs. Incident forms reviewed identified that family were notified following a resident incident. One relative interviewed (of dementia care resident) stated that they are informed when their family members health status changes.  Interpreter policy and contact details of interpreters is available. 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 information pack is available in large print and this can be read to residents. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Charles Fleming Retirement Village is a Ryman Healthcare facility. The service currently provides care for up to 140 residents at hospital, rest home, and dementia level care. On the day of audit there were 38 (of 40) rest home residents on level one (ground level), 36 (of 40) hospital level residents on level two, and 26 (of 40) dementia level residents across the two 20 bed special care units on level three. There are 20 serviced apartments certified for rest home level of care. There were seven rest home level of care residents in serviced apartments.  Ryman Healthcare has an organisational total quality management plan and a key operations quality initiatives document. Quality objectives and initiatives are set annually. The organisation wide objectives are translated at each Ryman service. Ryman Healthcare also has operations team objectives that include a number of interventions/actions. Each service also has their own specific Ryman accreditation programme (RAP) objectives 2015 and progress towards objectives is updated as part of the RAP schedule. The organisation completes annual planning and has a suite of policies/procedures to provide rest home care, hospital care and dementia care.  The village manager at Charles Fleming is non clinical and has been in the role for eight months. She is supported by a clinical manager who has been in the role for two years. The village manager has completed a comprehensive orientation to the role and has attended a two day managers training day. The management team is supported by the Ryman management team including a regional manager. |
| 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 | A quality and risk management system is being maintained. The service has policies and procedures to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Any new policies or changes to policy are communicated to staff as evidenced in meeting minutes.  Key components of the quality management system include (but are not limited to) monitoring falls, medication errors, restraint use, pressure areas, infections, wounds and resident satisfaction. Weekly reports by the village manager to the regional manager provide a coordinated process between service level and the organisation. Regular meetings are held throughout the service. There are monthly accident/incident reports that break down the data collected across the rest home, hospital, dementia unit and staff incidents/accidents. Falls prevention strategies are in place that includes the analyses of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. The internal audit programme monitors key components of the service. If a target is not met or an area of non-compliance is identified a quality improvement plan (QIP) is developed and implemented.  There is a comprehensive health and safety and risk management programme in place. There are policies to guide practice. |
| 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 | Individual incident reports are documented electronically for each incident/accident. Significant events were documented in the residents’ progress notes for two residents (one with falls and one pressure injury). Both incidents were traced and evidenced completed accident/incident forms. The previous finding has been addressed around reporting requirements. All accident/incident forms reviewed documents corrective actions taken and any follow up action required. The data is linked to the organisation's quality and risk management programme and is used for comparative purposes. Twenty Incident forms were reviewed (including six from the special care unit), all reviewed reflected timely clinical assessment and follow up by a registered nurse. There were no specific trends noted specifically in the dementia unit across the last six months.  Discussions with the village manager and clinical manager confirm their awareness of the requirement to notify relevant authorities in relation to essential notifications. Relevant authorities had been notified for an outbreak in August 2015. |
| 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 | The organisation provides documented job descriptions for all positions which detail each position’s responsibilities, accountabilities and authorities. Relevant documentation was seen in eight staff files reviewed. A register of practising certificates is maintained. Training requirements are directed by Ryman head office and reviewed as part of the RAP reporting. There is an enrolled nurse who oversees staff induction and the ACE programme and a clinical manager who facilitates the in-service calendar. Ryman ensures registered nurses are supported to maintain their professional competency.  There are currently 13 caregivers employed in the dementia unit. Five have completed dementia standards. Eight caregivers are working towards the completion of these unit standards. Two of the eight staff have commenced employment in the dementia unit in the past six months.  Ryman provide a comprehensive induction programme at Foundations Level 2 compliance and qualification to all care staff. Completion of induction programme and required ACE dementia standards are required to be monitored and reported monthly to head office as part of the RAP programme. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is Ryman policy which supports the requirements of skill mix, staffing ratios and rostering. There is a registered nurse and first aid trained member of staff on every shift. Caregiver’s interviewed stated that management are supportive and approachable. Staff interviewed across the three areas advised that there are sufficient staff on duty at all times. Interviews with residents and relatives confirm that there are sufficient staff on duty. The village manager advised they are currently recruiting more casual staff to assist when staff are sick. There were no identified gaps in the staff roster. The service uses a preferred agency when required. The roster sighted did not evidence staff working double shifts. The service has addressed a previous finding relating to staffing levels. A review of staff rosters did not identify any areas where staff were not replaced.  There are at least two registered nurses on duty in the hospital am and pm shifts and one at night. In the dementia unit, there is a RN at least daily across seven days. In the rest home there is a rostered RN at least daily across seven days. The caregivers cover a mix of full and half shifts. There are designated cleaners, laundry staff, activities staff, gardeners, and administration staff. The clinical manager works 40 hours per week and oversees the clinical care of all residents. The village manager also works 40 hours per week. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | Six resident files were reviewed. All entries in the progress notes were timed on entry, dated and identified the designation of the writer. The previous shortfall has now been addressed. |
| 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 Low | Registered nurses, enrolled nurses and healthcare assistants responsible for the administering of medication complete annual medication competencies and attend annual medication education. Registered nurses check medications on delivery against the medication chart and sign the back of the blister pack. The previous finding around checking of medication on delivery has been addressed. There were no self-medicating residents on the day of audit. Standing orders are not in use. Medication administration practice was observed to be compliant. There was no evidence of transcribing on the non-packaged signing sheets. The previous finding around transcribing has been addressed.  Fourteen medication charts sampled (six hospital, four rest home and four dementia care) had photo identification and allergy status identified. Not all medication charts had an indication for use of required medications. Medication charts reviewed identified three monthly medication reviews by the GP. |
| 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 | The service employs a qualified chef, cooks assistant and kitchen assistant daily to prepare and provide all meals on-site. There is a four weekly seasonal menu that has been designed and reviewed by a dietitian at organisational level. The newly introduced summer menu provides two options for the evening meals. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes. Soft/pureed, diabetic desserts, gluten free, vegetarian and alternative foods for known dislikes are provided. Food is delivered in hot boxes to each kitchenette and served from bain maries by healthcare assistants. Staff were observed sitting with the residents and assisting them with meals. Staff interviewed state there are nutritious snacks available 24 hours in the dementia care units. Adequate snacks were sighted in the kitchenette fridge and cupboards.  The service is well equipped with separate dishwashing area, baking, cooking and storage areas. The chiller temperature is checked twice daily. Fridge and freezer temperatures are checked and recorded at least daily in the main kitchen and kitchenettes. End cooked food temperatures are monitored on the midday and evening meals. All foods were date labelled. A cleaning schedule is maintained. Staff were observed wearing appropriate protective clothing. Chemicals used in the cupboard were stored safely.  Staff have been trained in safe food handling and chemical safety. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Residents interviewed reported their needs were being met. Relatives interviewed stated their relative’s needs were being appropriately met and they were informed of any changes to health and interventions required. When a resident's condition alters, the registered nurse initiates a review and if required a GP visit or nurse specialist consultation. The relative contact sheet evidences relative notification for any health changes.  Dressing supplies are available and treatment rooms are adequately stocked for use.  Continence products are available and resident files include a three day urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed and this could be described by the clinical manager and RNs interviewed.  Weight loss management plans were in place for two rest home residents with weight loss. The cook had received updated dietary profiles that included dietary supplements, smoothies, high protein and high calorie diets. The previous finding around weight loss management has been addressed.  Behaviour charts were evidenced to be in use for altered behaviours. Long term care plans documented pain management for residents who identified pain. The previous shortfall around behaviour charts and documentation of pain management has been addressed. |
| 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 team of activity officers (includes two diversional therapists) implement separate activity programmes for the serviced apartments, rest home, and hospital and dementia care units. They are supported by a Ryman occupational therapist that meets regularly with the team and oversees the engage activity programmes. The Engage programme is delivered Monday to Sunday in the hospital and dementia care units and Monday to Friday in the rest home. Resources are available for care staff to use at any time for activities in the weekends.  There are choices of activities for rest home (including rest home residents in serviced apartments) and hospital residents to attend. The activity officers ensure all residents are aware of the activities available and assist them in attending activities of their choice. Regular contact is made and one on one time spent with residents who are unable to participate in group activities or choose not to be involved in the activity programme. Each unit (including dementia care) ensures residents are taken for supervised walks/wheelchair walks in the grounds and gardens (weather permitted) or around the facility. Residents were observed to be engaged in the activities provided throughout the facility on the day of audit.  The activity officers are trained to deliver the Triple an exercise programme which is applicable to the cognitive and physical abilities of the resident group. The separate programmes include a variety of crafts, quizzes, clubs and groups, library trolley, entertainers, musical moments, news and views, reminiscing and meaningful activities such as gardening and baking. Community links are maintained with entertainers, speakers, visiting pets, card groups, stroke club visitors, and church services. Volunteers are involved in the activity programme. The service has a van for outings and there are outings/drives at least weekly for residents.  The resident/family/whanau as appropriate complete a resident profile. An activity plan is developed and the resident is encouraged to join in activities that are appropriate and meaningful. The activity plans were reviewed at the same time as the clinical care plans in resident files sampled. Resident meetings are held in the rest home and hospital units and family meetings in the dementia care unit that provide an opportunity for feedback on the activity programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The evaluation and care plan review policy require that care plans are reviewed at least six monthly. Resident files had written evaluations that described progress against each goal and need identified in the care plan (sighted on the electronic system and in resident files). Family are invited to attend the multidisciplinary team (MDR) review meetings. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building is currently operating under a certificate for public use (CPU) expiry 18 March 2016. |
| 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 | The surveillance policy described the purpose and methodology for the surveillance of infections. Definitions of infections are in place and appropriate to the complexity of the service provided. Individual infection reports are recorded electronically. Monthly data is reported to the combined infection prevention and control, and the health and safety meetings. Staff are informed through facility meetings held at the facility. The infection prevention and control programme is linked with the RAP. The infection prevention and control officer uses the information obtained through surveillance to determine infection prevention and control activities, resources, and education needs within the facility. There is close liaison with the GP's that advise and provide feedback to the service. Systems in place are appropriate to the size and complexity of the facility. There has been one outbreak since the previous audit. Documentation sighted demonstrated the outbreak had been managed well and contained in the one unit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy includes comprehensive restraint procedures. The policy identifies that restraint is used as a last resort. There were seven residents with restraint usage and no residents with enablers on the day of audit. The restraint coordinator is the clinical manager. The use of enablers/restraint is discussed at clinical meetings and RAP meetings. Challenging behaviour and restraint minimisation and safe practice education is provided. |

# 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 guidelines. | PA Low | Prescribing of regular medications met legislative requirements. Rest home and hospital level resident medication charts met prescribing requirements for as required medications. | Two of four medication charts reviewed in the dementia unit residents did not have a prescribed ‘indication for use’ for ‘as required’ medications (clonazepam, quietapine and intramuscular haloperidol). This was corrected on the day of audit. | Ensure as required medications have a prescribed indication for use.  30 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | All resident files sampled had initial assessments, long term care plans and evaluations completed by the RN within the required timeframes. There have been 14 new admissions to the service since 1 July 2015. Five residents have had InterRAI assessments completed. | Nine residents (two dementia care, one hospital level and six rest home level residents) who have been admitted to the service since 1 July have not has interRAI assessments completed within 21 days. | Ensure InterRAI assessments are completed for all residents within three weeks of admission.  60 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.

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End of the report.