

Bupa Care Services NZ Limited - Cedar Manor Rest Home & Hospital

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:	Bupa Care Services NZ Limited
Premises audited:	Cedar Manor Rest Home & Hospital
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: 25 May 2016 End date: 26 May 2016
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:	90

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Cedar Manor Care Home and Hospital is part of the Bupa group. The service is certified to provide rest home, hospital and dementia level care for up to 92 residents. On the day of the audit, there were 90 residents.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, relatives, staff and management.

The care home manager is appropriately qualified and experienced. Feedback from residents and relatives is positive. Two of the three shortfalls identified at the previous audit have been addressed. These were around signing and dating documents and timeliness of documentation. Improvement continues to be required around medication management.

Improvement is required from this audit around meeting minutes, staff education, care interventions and self-administration of medications.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and family are well informed including of changes in resident's health. The care home manager and clinical manager have an open door policy. Complaints processes are implemented. Complaints and concerns are managed and documented and learning's from complaints shared with all staff.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Cedar Manor has an established quality and risk management system that supports the provision of clinical care and support. An annual resident/relative satisfaction survey is completed and there are regular resident/relative meetings. Cedar Manor is benchmarked against other Bupa facilities. Incidents are documented and there is immediate follow up from a registered nurse. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care and support and external training is supported. The organisational staffing policy aligns with contractual requirements and includes skill mixes. Staffing levels are monitored closely with staff having input into rostering.

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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Resident records reviewed provide evidence that the registered nurses utilise the interRAI assessment to assess, plan and evaluate care needs of the residents. Care plans are developed in consultation with the resident and/or family. Care plans demonstrate service integration and are reviewed at least six monthly. Resident files include three monthly reviews by the nurse practitioner or general practitioner. There is evidence of other allied health professional input into resident care.

Medication policies reflect legislative requirements and guidelines. All staff responsible for administration of medicines completes education and medicines competencies. The medicines records reviewed included documentation of allergies and sensitivities and are reviewed at least three monthly by the general practitioner/nurse practitioner.

There are activities programmes in place for the rest home, dementia unit and hospital residents. The programme includes community visitors and outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food and baking is done on-site. All residents' nutritional needs are identified and documented. Choices are available and are provided. The organisational dietitian reviews the Bupa menu plans.

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.

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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A Bupa restraint policy includes comprehensive restraint procedures including restraint minimisation. A documented definition of restraint and enablers aligns with the definition in the standards. There are five restraints and four enablers being used. Enabler use is voluntary.

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 coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Bupa facilities. Staff receive ongoing training in infection control.

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	13	0	3	1	0	0
Criteria	0	35	0	4	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The number of complaints received each month is reported monthly to care services via the facility benchmarking spreadsheet.</p> <p>There is a complaints flowchart.</p> <p>The complaints procedure is provided to resident/relatives at entry and is prominent around the facility on noticeboards. A complaint management record is completed for each complaint. A record of all complaints per month is maintained by the facility using the complaint register. Documentation including follow-up letters and resolution reviewed demonstrated that complaints are well managed.</p> <p>Discussion with nine residents (four rest home and five hospital) and relatives, confirmed they were provided with information on complaints and complaints forms. Complaints reviewed were well documented including investigation, follow-up letters and resolution.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if family/whānau have been informed (or not) of an accident/incident. Incident forms reviewed identified that family were notified. As part of the internal auditing system, incident/accident forms are audited and a criterion is identified around "incident forms" informing family. Families often give instructions to staff regarding what they would like to be contacted about and when should an accident/incident of a certain type occur. This is documented in the resident files.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Five relatives interviewed (two dementia and three hospital) stated that they are always informed when their family members health status changes. There is an interpreter policy and contact details of interpreters.</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>	<p>FA</p>	<p>Cedar Manor provides rest home, hospital and dementia level care for up to 92 residents. The 74 beds in the 'hospital' and 'rest home' wings are dual purpose. There were 17 of a potential 18 residents in the dementia unit, 35 hospital level residents and 38 rest home level residents on the day of the audit. With the exception of one rest home level resident on respite care, all residents were under the ARRC contract.</p> <p>Cedar Manor set specific quality goals for 2016 and there is a monthly review of all goals.</p> <p>The care home manager has been in the role for three and a half years. He is supported by a clinical manager who has been at the service for 15 months and has 20 years of aged care experience. Managers and clinical managers attend annual organisational forums and regional forums six monthly.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>Cedar Manor has a quality and risk management system based on the Bupa organisation quality management systems and processes.</p> <p>The service has policies, procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. Policies are current and staff are informed of updates and changes.</p> <p>Key components of the quality management system link to the monthly quality, health and safety and infection control meetings, registered nurses meetings and staff meetings at Cedar Manor. However, meeting minutes do not reflect discussion of quality data trend analysis. Weekly reports by facility manager to Bupa operations manager and quality indicator reports to Bupa quality coordinator provide a coordinated process between service level and organisation.</p> <p>There are monthly accident/incident and infection benchmarking reports provided to Cedar Manor for rest home, hospital and dementia level care. Internal audits are completed according to the Bupa schedule. Corrective action plans are developed when service shortfalls are identified.</p> <p>There is a comprehensive hazard management, health and safety and risk management programme in place. There are facility goals around health and safety. The health and safety committee meets monthly and there is a current hazard register.</p> <p>Falls prevention strategies are in place.</p>

<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service documents and analyses all incidents/accidents. Individual incident reports are completed for each incident/accident with immediate action noted. The data is linked to the organisation's benchmarking programme and this is used for comparative purposes. Incident reports are assessed for a means to prevent recurrence before being signed off. All incident forms reviewed documented immediate follow up by a registered nurse including completion of neurological observations for all unwitnessed falls or falls with a possible head injury. All pressure injuries (previous) had been reported as incidents and are benchmarked.</p> <p>Discussions with service management, confirms an awareness of the requirement to notify relevant authorities in relation to essential notifications. One appropriate section 31 notification has been made.</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>	<p>PA Low</p>	<p>A register of practising certificates is maintained.</p> <p>Six staff files reviewed (two registered nurses including a unit coordinator, two caregivers, a cook and an activities coordinator) included appropriate employment documentation and up-to-date performance appraisals and documentation.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice including around caring for those with dementia. The orientation programme is developed specifically to worker type (e.g. RN, support staff) and includes documented competencies. Completed orientation booklets are on staff files. Five caregivers interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>An annual education schedule is being implemented. In addition, opportunistic education is provided by way of toolbox talks. Attendance at in-service education sessions is low. Registered nurses (RN's) are provided with suitable training. A competency programme is in place with different requirements according to work type.</p> <p>There are 15 caregivers that work in the dementia unit. Eight have completed the required dementia standards and the other seven have not yet been employed for twelve months.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>An organisational staffing policy aligns with contractual requirements and includes skill mixes. There are at least two registered nurses on duty twenty-four hours per day (one in the rest home wing and one in the hospital wing). Additionally, the dementia unit coordinator (registered nurse) works 40 hours per week. The clinical manager is also a registered nurse and work 40 hours per week. Interviews with relatives and residents all confirmed that staffing numbers were good. Caregivers interviewed stated that they have sufficient staffing levels.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The previous audit identified that changes to interventions on care summaries were not always dated and follow up on incident forms by RNs were not always dated or included times. All documents sampled during this audit (including care summaries and changes to incident forms) were signed and dated. The previous shortfall has been addressed.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice</p>	PA Moderate	<p>Medication rooms/cupboards were checked across the three areas. Registered nurses in the hospital, and senior caregivers in the rest home and dementia unit, administer medications. All staff administering medications have completed an annual medication competency. Registered nurses also complete an annual syringe driver competency.</p> <p>The service uses a robotic roll system for medications. All medications are checked on delivery against the medication chart and discrepancies are fed back to the supplying pharmacy. There is a small supply of hospital stock kept in a locked cupboard in the hospital medication room.</p> <p>The 14 medication charts sampled were clear and easy to understand and they included photo ID and allergies. The medication folder contained information on crushable medications and warfarin precautions. Antipsychotic medication management plans were in place for residents on these medications.</p>

guidelines.		<p>'As required' medications signed as given in the dementia and rest home unit did not all include documented times of administration. This previous audit finding remains open. This audit also identified that start and stop dates for short-term medication are not always documented and/or signed by the prescriber, staff had not consistently signed for regular medications and one resident had two medication charts. Self-administering residents did not all have documented three monthly GP review of the self-medication competency.</p> <p>All medication charts sampled showed evidence of being reviewed by the GP three monthly.</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>Cedar Manor continues to prepare and cook all meals on-site in the main kitchen. The food is transported to the dining rooms in bain maries. The temperature of the food is checked before leaving the kitchen and again before being served. There is a cook on duty daily and she is supported by a morning and evening kitchen hand. All kitchen staff have an up-to-date food safety and hygiene certificate. There is a kitchen manual and a cleaning schedule. Chemicals are stored in a locked cupboard and safety data sheets are available. Personal protective equipment is worn as appropriate. There are Bupa seasonal menus on a six weekly cycle and these have been approved by a consultant dietician. The cook receives dietary information for new residents and is notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are written up the kitchen whiteboard. Normal and moulied meals are provided. Snacks are available for residents in the dementia unit. Fridge and freezer temperatures are recorded daily (sighted). Temperatures are recorded on all chilled and frozen food deliveries. All food in the chiller, fridges and freezers are dated. There is sufficient food stored to last for at least three days in an emergency. Stock is rotated by date. The kitchen is well equipped, clean and tidy. Food satisfaction surveys are done annually. Residents and relatives interviewed spoke positively about the food provided.</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>	PA Low	<p>All resident files reviewed had a documented care plan and care plans documented updates with changed care needs. When a resident's condition changes the RN initiates a GP/NP visit or nursing specialist referral. Residents interviewed reported their needs were being met. Family members interviewed stated the care and support met their expectations for their relative. There was documented evidence of relative contact for any changes to resident health status. Interventions for behaviour that challenges, consistent instructions in care plans and pain assessments were not always documented.</p> <p>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 RNs interviewed. Caregivers and RNs interviewed state there is adequate continence and wound care supplies.</p> <p>Wound assessment, wound management and evaluation forms and short-term care plans were in place for all wounds. There were eight skin tears and four chronic wounds for hospital residents, four skin tears and one chronic</p>

		<p>ulcer in the rest home and four skin tears for residents in the dementia unit. There were four facility acquired pressure injuries.</p> <p>Monitoring charts were utilised, examples sighted included (but not limited to): weight and vital signs, blood glucose, food and fluid, turning charts and behaviour monitoring as required.</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>	FA	<p>Cedar Manor continues to provide a varied and well attended activity programme for residents. Three activities coordinators are based in each of the three units. The activity team attend Bupa training days and regional meetings/workshops held quarterly.</p> <p>Since the previous audit, the service has reviewed the activity programme and have included activities based on resident feedback and from staff researching programmes that might appeal. New activities have included a knitting club, dancing, inter-rest home games, running man challenge, high teas and 'too fit to sit' exercises. Since this initiative the service reports that attendance has improved, as evidenced by additional chairs required and more snacks ordered as part of the activity.</p> <p>The weekly activity programme is displayed on noticeboards. There are a range of activities to meet most needs including entertainment, bingo bowls and games. Group exercises are held for half an hour three times a week. There is a shop trolley, which goes out weekly. Church services are held twice a month. Variations to the programme are notified to the residents.</p> <p>In the dementia unit, there are activities in place and each resident has a documented 24 hour activity plan. Residents from the dementia unit also attend activities in the rest home or hospital. There are memorabilia available to residents. On the day of audit, activities were seen to be taking place and most residents were actively engaged.</p> <p>The activity assistant has one on one time with residents who are unable or who choose not to participate in the programme. There are van outings a week arranged for all residents to enjoy.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>In files sampled care plan evaluations were documented by the registered nurses. Six monthly multidisciplinary reviews (MDT) were completed by the registered nurse with input from caregivers, the GP, the activities coordinator and if applicable the physiotherapist. Family are invited to attend the MDT review. Files sampled also had short-term care plans available to focus on acute and short term issues. These were evaluated regularly.</p>
Standard 1.4.2:	FA	The service has a current building warrant of fitness that expires on 26 February 2017.

<p>Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</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>The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Individual infection report forms are completed for all infections. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. Infection control data is collated monthly but not reported at the quality, infection control and staff meetings (link 1.2.3.6). The infection control programme is linked with the quality management programme.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. There is close liaison with the GP's that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</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>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 process of assessment and evaluation of enabler use is the same as a restraint and included in the policy.</p> <p>There were five hospital residents with restraint and two hospital residents with enablers. There is a strong drive to reduce restraints and involve families/EPOA in the process. Review of restraint usage is completed in the facility and is benchmarked against the organisation. Residents' files for residents with enabler's showed that enabler use is voluntary.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Incidents, accidents and infection data is analysed for trends and benchmarked against other Bupa facilities for each level of care provided. Trends identified from data analysis are acted upon via quality data corrective action plans. However, trend analysis and outcomes of trend analysis were not documented as discussed in meeting minutes.	Infection control, quality and staff meeting minutes did not document discussion around analysis of trends of accident/incident or infection control data.	<p>Ensure quality data analysis results are communicated to service providers.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide</p>	PA Low	A variety of appropriate in-service education has been provided, which, if sufficient staff attended, would meet all requirements. In addition to formal education, short ‘toolbox’ talks are provided for staff on topical issues.	Staff attendance numbers are very low meaning insufficient staff have completed required trainings. For example, (out of 100 staff), over 2015 and 2016 to date, three have attended health and safety training,	Provide evidence that sufficient staff have attended compulsory and scheduled

safe and effective services to consumers.			two falls prevention training, six pressure injury prevention training, eleven infection control training, eleven challenging behaviour management training and six cultural safety training.	training. 90 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>	<p>PA Moderate</p>	<p>There is a comprehensive range of policies and procedures in place to guide staff around all aspects of medication management. The service has a comprehensive training programme and competencies in place to ensure staff provide a safe medication service. Medication administration was observed at three times during the audit and practice was appropriate during these medication rounds (observed in each of the three units). Medication documentation and appropriate signing for both prescribers and for staff on administration was not always in place and one resident had two medication charts.</p>	<p>(i) Start and stop dates and/or a prescriber signature for short-term medication was not present for three dementia and two hospital medication charts.</p> <p>(ii) 'As required' medications did not have the time of administration documented for one rest home and two dementia charts.</p> <p>(iii) One hospital resident medication files reviewed evidenced two medication charts.</p> <p>(iv) Gaps in staff administration signatures were noted on regular medications for two rest home charts.</p>	<p>(i) Ensure that prescribers document all medications as per direction on the chart and policy.</p> <p>(ii) Ensure that 'as required' medications have the time of administration documented.</p> <p>(iii) Ensure residents have only one medication chart.</p> <p>(iv) Ensure that staff always sign on administration.</p> <p>30 days</p>

<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>The service facilitates self-medication by residents in the rest home. The process includes a three monthly GP review of competency. This was not always documented.</p>	<p>One resident who self-administers in the rest home did not have a three monthly GP review of the consent/competency as per policy.</p>	<p>Ensure that the GP reviews the self-medication competency three monthly.</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>	<p>PA Low</p>	<p>Seven resident files were reviewed for this audit. All residents had a care plan in place. Interventions were not fully documented for all identified issues. One care plan documented conflicting instructions. Care staff interviewed were able to describe the care and support needed (hence the low risk).</p>	<p>(i) One rest home level care plan contradicted itself with regard to how often the resident should be weighed.</p> <p>(ii) One resident in the dementia unit, with behaviours that challenge, did not have interventions documented to manage the behaviour.</p> <p>(iii) Ongoing pain assessments for two rest home and two hospital residents with identified pain were not documented.</p>	<p>(i) Ensure care plans document consistent advice.</p> <p>(ii) Ensure care plan interventions are documented for behaviour that challenges</p> <p>(iii) Ensure ongoing pain monitoring is documented for resident with identified pain.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.