

Wilding International 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](#).

The specifics of this audit included:

Legal entity:	Wilding International Limited	
Premises audited:	Armourdene Rest Home	
Services audited:	Rest home care (excluding dementia care)	
Dates of audit:	Start date: 1 December 2016	End date: 2 December 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:	22	

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

Armourdene Rest Home provides care for up to 28 rest home residents. During the audit, there were 22 residents including three borders that pay privately. Armourdene is privately owned and operated. The owner undertakes managing director role and supported by an assistant manager and the quality/administration manager. The owner has owned the facility since 2004 and owns and manages another rest home which is in the proximity to Armourdene Rest Home. All staff including management, staff and some other resources are shared by the two sites.

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

Three of four audit findings from the previous report around documenting timeframes in the clinical records, service delivery interventions and conducting annual performance appraisals have been addressed. Further improvements are required around implementation of the quality and risk management programme.

This audit has also identified shortfalls around health & safety policies, interRAI assessments, care planning evaluations, pain management and implementation of medication management system.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
--	--	--

Open disclosure principles are implemented. Complaints processes are communicated to residents and families and the complaint register is 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 medium or high risk and/or unattained and of low risk.
---	--	--

There is a documented quality and risk management system. Implementation of the quality and the risk management system is overseen by the assistant manager and quality/administration manager. Registered nurses take part in the clinical aspect of the quality and risk management system. Adverse event reporting occurs and required follow ups are completed.

There are human resources management processes in place and annual performance appraisals are completed. New staff receive an orientation programme prior to their commencement of care to residents. A staff education programme is implemented.

Staffing levels and skill mix are appropriate for the service level to provide safe service delivery. Resident's files reviewed showed accurate and appropriate resident information management systems.

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
---	--	---

Each stage of service provision is provided by suitably qualified and experienced staff that are competent to perform the function. Family communication sheets are maintained. Resident and family interviews confirmed their input into assessment, service delivery planning, care evaluations and multidisciplinary reviews.

The activities coordinator is newly employed in her current position. The activities programme provides a sufficient range of planned activities to maintain resident's strengths and interests which include the involvement of the residents into the community. Residents interviewed confirm their satisfaction with the programme.

Registered nurses and medicine competent caregivers administer medication. All food is cooked on-site. The current menu has been reviewed by a dietitian.

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.
--	--	--

Armourdene Rest Home holds a current warrant of fitness, which expires on December 2017.

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.
---	--	--

Armourdene Rest Home maintains a restraint-free environment. There were no restraints or enablers being utilised.

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.
---	--	--

Infection control surveillance undertaken is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant staff or other professionals 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	13	0	2	2	0	0
Criteria	0	33	0	5	2	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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>Information about the complaints process is included in the resident admission pack and displayed in the entrance in the facility, together with complaints forms. Two registered nurses (RNs) interviewed confirmed that the complaints process is discussed with the resident and family during the admission process. Resident and family interviews confirmed awareness of their right to make complaints if necessary.</p> <p>Staff interviewed could discuss the process around reporting complaints.</p> <p>The complaints register and associated records identified no complaints in 2016.</p>
<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>Communication logs in resident records confirmed open disclosure of adverse events and consultation with families regarding the changes in plan of care. Resident meetings occur and the owner/managing director and the assistant manager have an open-door policy. Two family members interviewed stated that they can talk to management or staff and can request changes if needed. The family members also confirmed that they are contacted if there are changes in a resident's health status. Accident/incident forms evidenced family notification following an incident or a section is completed to indicate a reason why the family have not been informed.</p> <p>Resident interview confirmed that all staff are known by them and staff wear name badges. Interpreter services</p>

		can be accessed.
<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>Armourdene Rest Home provides care for up to 28 residents. During the audit, there were 22 residents including 3 borders that pay privately.</p> <p>A mission statement, values and philosophy have been developed for the service. There is a quality and risk management programme that is managed by the assistant manager and the quality/administration manager.</p> <p>Armourdene is privately owned and operated. The owner undertakes a managing director role and is supported by an assistant manager and the quality/administration manager. The assistant manager is newly appointed to her role and was previously employed as an activities coordinator.</p> <p>The owner has owned the facility since 2004 and owns and manages another rest home which is in close proximity to Armourdene. All staff including the management team and some other resources are shared by the two sites.</p> <p>The clinical oversight role is shared by the two RNs. One RN has over 20 years' experience in the aged care sector and the second RN is relatively new in her role. The assistant manager and the managing director have completed external training related to managing an aged care facility.</p> <p>Armourdene Rest Home has respite care, Young People with Disability and Long Term Chronic Health Conditions contracts with the local DHB. The managing director confirmed that there were no residents receiving care under these contracts currently.</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>	PA Moderate	<p>There is a documented quality and risk management system. Implementation of the quality and the risk management system is run by the assistant manager and quality/administration manager and overseen by the owner/managing director. Registered nurses take part in the clinical aspect of the quality and risk management system such as clinical audits, follow up on incident and accident reports and infection control surveillance.</p> <p>The staff training programme is implemented. Incidents and accidents are reported, analysed and communicated to staff. Falls prevention and management is well documented.</p> <p>There is an internal audit schedule, a meeting structure, a training programme for staff, infection control surveillance, the restraint minimisation programme, health and safety for staff and residents and the managing of complaints or any other adverse events that may occur.</p> <p>Document review and discussion with quality/administration manager confirmed that the quality and risk management plan had not been fully implemented. A corrective action was required at the previous audit around implementation of the internal audit programme and communication of the results to staff. This</p>

		corrective action has not been fully addressed yet.
<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>	FA	<p>Document review and staff interviews confirmed that incidents and accidents are documented and staff are encouraged to complete the documentation when incidents happen. All adverse events are reported to management and families in an open and frank manner. Interviews with staff confirm that they understand their obligation to report adverse events. Incident/accident reports reviewed included required immediate action and any follow up actions. Ten incident forms reviewed demonstrate clinical follow-up by a RN. Discussions with the owner/managing director confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications. Two family members interviewed stated that they are always informed of incidents and they had no concerns around management of clinical risks.</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>There are 37 staff employed in various roles to cover the two facilities. Seven staff files reviewed included (but not limited to): interview notes, validation of qualifications, appointment letters, contracts and reference and police checks. Staff receive ongoing training. The in-service programme is implemented and attendance records are maintained.</p> <p>Medication competencies are completed by caregivers who administer medication. Since the previous audit, the rest home had completed a quality initiative that includes three times competency review by RNs to confirm the medicine competency.</p> <p>Three caregivers interviewed confirmed access to sufficient training. Two RNs and the assistant manager stated that they have completed external training. The senior RN completed a professional development recognition programme. Annual practising certificates for RNs were sighted in the personal files.</p> <p>Five out of seven files included annual performance appraisals (two were not due as they were employed in the past six months). This is an improvement since the previous audit. All staff files reviewed reflected evidence of an orientation programme that had been completed. Interviews with three caregivers confirmed that their orientation to the service was thorough.</p> <p>The annual training programme exceeds eight hours annually.</p> <p>There are three interRAI competent RNs.</p>
<p>Standard 1.2.8: Service Provider Availability</p>	FA	<p>Staffing levels and skill mix are appropriate for the service level to provide safe service delivery. There are two caregiving staff on duty at each shift. Cleaning and laundry duties are shared by all staff over three shifts.</p>

<p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>There is a RN on morning duty over five days a week. Two RNs share on call duties and the assistant manager lives near the home during weekdays.</p> <p>Armourdene Rest Home employs three registered nurses (one is currently on maternity leave). There is also one casual RN available as needed. The assistant manager stated that all staff work at both facilities and therefore rostering can manage staff absences and leave easily.</p> <p>General practitioner (GP) interview confirmed satisfaction with the nursing team who provide appropriate and timely referrals on behalf of their residents.</p> <p>Staff, family and resident interviews confirm sufficient staffing.</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>	<p>FA</p>	<p>Six resident's files reviewed identified accurate and appropriate resident information management systems. Initial information including short-term care plans were recorded within 24 hours of entry and sufficient information was collected to manage resident needs. Resident files reviewed were integrated and included GP assessments and reviews. There was evidence of external health professional involvement where relevant.</p> <p>Progress notes were legible and the designation of the person who completes the entry was recorded. All six files reviewed also had time of entry recorded by the person who completed the entry. Therefore, the required corrective action from the previous audit 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 guidelines.</p>	<p>PA Moderate</p>	<p>Registered nurses and medication competent caregivers administer medication. Ten sampled files reviewed identified that medicine competencies were maintained yearly and staff were observed three times before they are signed as competent.</p> <p>Medications were kept locked. A small amount of stock medications was stored and stock control was maintained.</p> <p>A procedure is in place for the self-administration of medicines but self-medication administration is not monitored. Review of sampled medication files and resident's records identified shortfalls around medication administration.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual</p>	<p>FA</p>	<p>Food service policies and procedures are appropriate to the service setting with a seasonal four-weekly menu. The menu was last reviewed by a dietitian in November 2014. There are documented protocols for management of residents with unexplained weight loss or gain, including referral to a dietitian and speech language therapist, as required. The cook is aware of residents who have been identified with weight loss and the resident's individual dietary needs. Dietary requirements were identified, documented and reviewed on a</p>

<p>food, fluids and nutritional needs are met where this service is a component of service delivery.</p>		<p>regular basis, as part of the care plan review. Interview with the cook confirmed that special diets and residents likes and dislikes were catered for.</p> <p>Food safety training for staff has been conducted. Four residents interviewed were satisfied with the food services provided and reported that their individual preferences were well catered for. Residents can feedback on the food services at the residents meeting.</p> <p>All foods were labelled and the cook described rotation of the dry goods. Food temperatures were recorded; however, fridge and freezer temperatures were not monitored since September 2016 (link 1.2.3.6)</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 Low</p>	<p>Two family members and four residents interviewed reported that residents' individual needs were appropriately met and they were actively involved in planning of care. Care plan interventions were linked to resident's assessed needs. Observation charts and monitoring forms around behaviour and pain were completed as indicated in the care plans. Specialist recommendations were followed up. Therefore, required corrective actions from the previous audit have been addressed; however, there is a gap around management of pain.</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>The activities coordinator was newly employed in her current position. She has two years' experience in aged care sector in a similar role. The activities programme provides a sufficient range of planned activities to maintain resident's strengths and interests which include the involvement of the residents into the community. Resident's social history and their preferred activities were identified on admission and these were documented in the resident's file.</p> <p>Individual activity plans have been reviewed when care plans are reviewed.</p> <p>Residents, family and staff interviews confirm that the activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and birthday celebrations.</p> <p>Resident meetings are facilitated by the activities coordinator and include discussion around the activities plan. Activities progress notes are maintained.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>Evaluation is conducted by the RNs with input from the resident, family, caregivers, activities coordinator and the GP. Families are notified of any changes in resident's condition. Four residents interviewed confirmed their participation in care plan evaluations. There is recorded evidence of additional input from specialist or multidisciplinary sources if this is required. Residents' files evidence referral letters to specialists and other</p>

comprehensive and timely manner.		<p>health professionals.</p> <p>There is at least a three-monthly review by the GP for medically stable residents.</p> <p>Short-term care plans are being used widely by RNs and changes in health status were documented in progress notes.</p> <p>Two out of six files reviewed showed that care plan evaluations were overdue (link 1.3.3.3).</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>	FA	<p>There is a current building warrant of fitness which expires in December 2017.</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>	FA	<p>The infection control coordinator collates infection control data monthly. These monthly results are presented as graphs and available for all staff to view.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Surveillance data includes all infections and outcome of treatments.</p> <p>Infection control data has been communicated to staff at staff meetings and staff are made aware of any infections of individual residents by way of feedback from the RN's, verbal handovers, short-term care plans and progress notes. Residents' files evidenced the residents who have been diagnosed with an infection had a short-term care plan.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Armourdene Rest Home continues to maintain a restraint-free environment and there were no enablers in use. Interview with a RN, three caregivers and document review confirmed that there have been no restraints or enablers used since the last audit. Staff interview confirmed knowledge and understanding in safe use of restraint and enablers. Staff gave examples around managing challenging behaviour and use of de-escalation techniques to preventing the use of restraint.</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>	<p>PA</p> <p>Moderate</p>	<p>Infection control data and incidents and accidents data were reviewed monthly and results were communicated to staff. Other clinical data such as weight loss and falls data were also communicated to staff in a timely manner. Three caregivers interviewed confirmed that this occurs. However, the internal audit programme is not fully implemented. This was a partial attainment at previous audit and has not been addressed yet. Hazards were reported by staff and follow up was completed by the RNs, however the hazard register was not up to date.</p>	<p>(i)The internal audit schedule has not been fully implemented. Therefore, there is a lack of documented evidence to reflect internal audit results being fully communicated to staff. (ii) Fridge temperatures monitoring did not occur since September 2016. (iii) There have been no consumer satisfaction surveys since 2013. (vi) The internal audit schedule includes the quality review of the programme which was scheduled in April 2016; however, this review has not been completed.</p>	<p>Ensure that the quality programme is fully implemented.</p> <p>90 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective actions were documented on incident/accident reports and signed off as completed. However, internal audit forms and staff meeting minutes did not include if corrective actions were addressed.</p>	<p>Internal audits were implemented from January to March 2016, however identified issues and deficiencies were not followed up, and required action plans were not signed off as completed. Several issues were also identified in the staff meetings but follow up on these issues was not documented.</p>	<p>Ensure that corrective actions are implemented and signed off as completed.</p> <p>90 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include: (a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk; (b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>A health and safety programme is documented which includes a hazard identification policy and hazard register. Contractors receive a health and safety induction programme. Health and safety is also included in the staff induction programme.</p>	<p>(i)The health and safety policies have not been updated yet to align with new Health and Safety at Work Act 2015; (ii) The hazard register has not been reviewed in the last 12 months and does not include current reported hazards.</p>	<p>Ensure that health and safety policies are reviewed and align with the updated Health and Safety at Work Act 2015; (ii) Ensure the hazard register is reviewed and up to date.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management</p>	PA Moderate	<p>Administration of medication at midday was observed and was safe. Medication</p>	<p>(i)In one occasion, a controlled drug not administered was returned to the safe, but it</p>	<p>(i)Ensure that two staff sign</p>

<p>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>errors are reported by staff and the RNs follow up. However, there was one identified episode where this was not reported.</p> <p>Expired medications are returned to pharmacy. All eye drops are dated on opening. 'As required' medications administered were documented correctly.</p> <p>Medication charts have been reviewed three-monthly by the GP and this was evident in all 10 files reviewed. Review of 10 medication files identified documentation shortfalls around safe medication administration.</p>	<p>was only signed by one staff member. The medication chart was signed to acknowledge that this controlled drug was administered. Progress notes identified that the resident was unconscious and transferred to the public hospital. Therefore, the controlled drug was not administered. (ii) Two out of ten medication charts had signing gaps. (iii) One insomnia medication was charted once a day but in one occasion it was administered twice a day and this was not reported to the RN.</p>	<p>for controlled drugs. (ii) Ensure that medications are signed when administered or 'the reason not given' is recorded. (iii) Ensure that medication is administered as prescribed.</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>Armourdene Rest Home facilitates self-medication but monitoring of self-administration of medicines on a daily basis was not recorded.</p>	<p>On the day of audit, there was one resident who self-administers medicine who had an up-to-date competency assessment. Self-administration competency was regularly reviewed by the RNs and the GP but self-administration of medicines on a daily basis was not recorded.</p>	<p>Ensure that self-medication is monitored and recorded in the resident's medication file.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time</p>	<p>PA Low</p>	<p>All six files reviewed identified that the GP had assessed the residents as stable and were to be seen three-monthly. More frequent GP reviews were sighted in the resident's file. Initial</p>	<p>Six resident files reviewed showed that two out of six interRAI assessments were not completed within six months and care plan evaluations were overdue for these residents. Further samples of three files evidenced that</p>	<p>Ensure that interRAI assessments and care plan evaluations</p>

frames that safely meet the needs of the consumer.		assessments were completed within 24 hours of admission and care plans were developed within three weeks of admission using interRAI assessments. Issues were identified around timeframe of interRAI assessments and care plan evaluations.	two of them were not reviewed within six months. On interview with both RNs confirmed that due to unavailability of the third RN who was on maternity leave, they were unable to keep up with their work load.	are completed at least six monthly. 90 days
<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 Low	Six residents' files sampled evidenced that care plan records were appropriate and interventions were based on the assessed needs, desired outcomes or goals of the residents. The required encouragement, direction, or supervision of a resident was recorded in the care plans. GPs documentation and records were current. Four residents and two family members interviewed confirmed that their and their relative's current care and treatments they are receiving meet their needs. Three caregivers and two RNs interviewed were knowledgeable around resident's current nursing cares. Monthly weighs or observations were evident in the files reviewed. Pain management is an area that requires improvement.	One out of six files reviewed showed that administration of prn medication and pain management were lacking RN input. For example: (i)- An elixir form of a controlled drug was stopped and a tablet form was re-started, however staff continued to use the liquid form because new tablets were not received from the pharmacy. (ii) Resident progress notes and pain assessments showed that the resident was complaining about pain, however an 'as required' controlled drug was prescribed 4-6 hourly was only administered once a day for two consecutive days, then the resident was transferred to the public hospital. Progress notes did not show RN input in pain management. Caregivers and a RN interview confirmed that caregivers were not always contacting an RN in regards to 'as required' pain relief.	Ensure that there is registered nurse involvement in pain management and appropriate use of prn medication. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.