

Pinehaven Cottage 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Pinehaven Cottage Limited	
Premises audited:	Pinehaven Cottage	
Services audited:	Rest home care (excluding dementia care); Dementia care	
Dates of audit:	Start date: 24 February 2017	End date: 24 February 2017
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:	29	

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

Pinehaven Cottage Limited is an aged care facility that provides rest home and secure dementia care for up to 34 residents.

This unannounced surveillance audit was conducted against the relevant Health and Disability Services Standards for aged care and the service's contract with the district health board. The audit process included the review of documentation, observations and interviews. The audit report is an evaluation of the combined evidence on how the service meets each of the standards.

There were five areas requiring improvement from the previous partial provisional audit that needed to be implemented prior to the opening of the dementia unit. These were closed off by the DHB prior to occupancy of the unit. There was one area for improvement related to annual performance reviews from the last certification audit, this has now been addressed.

From this surveillance audit there are three new areas requiring improvements related to timeframes for assessment and care planning, the documented activities plan in the dementia unit, and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There was evidence that staff communicate effectively with residents and provide an environment conducive to good communication. There are processes in place to access interpreting services when this is required.

The service has an easy to use complaints management system. There is a complaint register that contains any complaint received and actions taken to address any shortfalls.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Organisational structures and processes are monitored at organisational level. Service performance is aligned with the organisation`s philosophy and goals identified in the quality and risk plan.

The service is managed by a suitably qualified and experienced enrolled nurse. The manager is support by a management team (owners) who have a mix of clinical and non-clinical experiences. There are registered nurses on duty seven days a week.

The service has a documented quality and risk management system that supports the provision of clinical care and support. Policies are regularly reviewed by the management team/quality team. The quality and risk performance data is reviewed and reported through the quality meetings. Review at the quality meetings includes incidents/accidents, infections, complaints and reports from the internal audit programme.

The adverse event reporting system is planned and coordinated with staff documenting and reporting adverse, unplanned or untoward events.

Systems for human resources management are established and implemented. The education programme for all staff is available and planned for the year. The required training for staff who work in the dementia unit is provided. There is sufficient staff numbers and skill mix to meet the needs of the residents in the rest home and dementia unit.

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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The service is coordinated in a manner that promotes continuity in service delivery and a team approach to care delivery. The care plans reviewed described the required support and interventions consistent with residents' assessed needs. The long term and short term care plans are evaluated at least six monthly, or sooner if there is a change in the resident's needs. Where progress is different from expected, the service responds by initiating changes to the care plan or with the use of short term care plans.

An activities programme is managed and implemented by providing a variety of group and individual activities to meet the interests of residents. There are activities staff for the rest home and secure dementia unit.

Staff who assist in medication management are assessed as competent to perform their roles.

The menu has been reviewed by a registered dietitian as suitable for the older person living in long term care. Snacks are available 24 hours a day. There were no negative comments made during interviews related to food.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

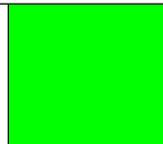


Standards applicable to this service fully attained.

There is a current building warrant of fitness and approved evacuation scheme. There have been no changes to the layout of the building, since the opening of the secure dementia unit.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.



Standards applicable to this service fully attained.

The service operates a restraint free environment and has no recorded restraint. Any enabler use is documented as being voluntary and the least restrictive option to maintain resident safety, comfort or independence. Clear definitions in the policies and ongoing education ensures staff understand the implication of restraint and enabler use.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control coordinator collates the monthly surveillance data and this is reviewed and analysed for trends, with any identified actions to be implemented reported. The infection surveillance results are reported at handover and staff meetings.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	0	2	1	0	0
Criteria	0	43	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 complaints process sighted identified the required procedures. Complaints are dealt with in a professional manner with consideration to any cultural or other values. Complaints are actively managed in a timely manner and in accordance with the complaints policy, and any other statutory requirements relevant to the specific situation.</p> <p>Complaints management information is included in resident information packs given on admission, and as confirmed by the nurse manager, the process was discussed with family/whanau and residents as part of the admission process. Complaints forms are accessible to staff, residents and family as required. The complaints register records the complaints, dates and actions taken. The complaints sampled were resolved within times frames outlined in Right 10 of the Code.</p> <p>Staff interviewed confirmed their understanding of the complaints process.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	FA	<p>The service has policy related to the use of interpreter services, as required. Staff education related to appropriate communication methods has been conducted. Staff reported that they understand the process for accessing interpreter services. All residents have English as their first language, with appropriate communication strategies implemented for the residents with cognitive impairment. Staff confirmed there are no issues with communicating with the resident.</p>

<p>environment conducive to effective communication.</p>		<p>The family/whānau members interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in each resident's file through the family communication sheet, on the accident/incident forms and in the residents' progress notes.</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>The service is licensed to provide care for up to 17 rest home residents and 17 residents in the secure dementia unit. At the time of audit there were 13 dementia level of care residents and 16 in the rest home (including one person under the age of 65). Services are provided to meet the individual needs of each of the residents. The services aim to maintain or restore maximum independence for residents with their function of daily living.</p> <p>The business, quality, risk and management plan (last reviewed February 2017), contains the organisation's mission, values and goals. There are long term and short term goals within the plan. The plan is reviewed on an annual basis, with aims and ambitions for 2017 documented.</p> <p>The manager is an enrolled nurse with a current practising certificate. The manager's job description describes their responsibilities, accountabilities and authorities. The manager has been at the service for 12 years and the manager for 10 years. The manager is supported by the owners, who have a mix of clinical (occupational therapy), management and non-clinical experience. The facility is a member of an aged care association, and regular updates and education is received on current legislation and issues related to management of aged care services. The facility manager has attended over 8 hours of education in the past 12 months related to management in the aged care sector. The service has registered nurse (RN) support seven days a week.</p> <p>The family/whānau and residents confirmed they are satisfied with the services provided. Families comment the owners and manager are approachable and listen and act on any concerns.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The quality and risk plan details the risks, current controls and ongoing actions required to provide safe and appropriate care. The quality and risk systems are monitored through the quality meetings. Each of the quality goals and ambitions for 2017 cover all aspects of care and service delivery. Staff are actively involved in the quality programme and demonstrated an understanding of what the organisation aims to achieve. The outcomes of the internal auditing and quality management systems are discussed at the staff meetings. Staff confirmed they understood and implement the quality and risk management systems.</p> <p>The policies are developed by an external aged care consultant. All policies and procedures sighted were up to date, reflected current good practice and met legislative requirements. The organisation currently reviews all documents in a two yearly cycle, or more frequently if there is best practice or legislative changes. All</p>

		<p>documents have a version control footer that includes the date when the policy was last reviewed. The document control system ensures that obsolete documents were removed from use. The review of policies or any updates are distributed to staff to read and they sign that they have understood any changes. Recent policy updates include the implementation of the interRAI assessment and care planning.</p> <p>The organisation had a documented quality and risk management plan which identified risks and showed the strategies in place to manage risks. All potential and actual risks are reported at board level and reviewed regularly. Clinical risks are discussed at staff meetings as confirmed in meeting minutes sighted and confirmed by staff.</p> <p>Quality data collection and analysis is maintained by the service and evaluation of results shared with staff and management. Quality improvements are put in place where indicated. The internal audit form records the identified issue, actions needed, who is to implement the actions and the review of when the actions have been implemented. Staff confirmed that all follow up actions were discussed during handover and at regular staff meetings. Data is collected, trended, reviewed and evaluated for all key components of service (complaints, incidents and accidents, health and safety, hazards, restraint and infection control). The graphs and analysis of the quality data is displayed in the staff room.</p> <p>The risk, hazard and emergency response plan identifies potential and actual hazards. The plan includes what the hazard is, risk level, preventative actions and ways to minimise risk.</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 manager understands their obligations for reporting serious harm and essential notifications. There have been no incidents or accidents that have required essential notification since the last audit.</p> <p>Staff demonstrated knowledge of when they are required to complete an incident/accident form. There is a monthly analysis of the incident and accident reports. The analysis of the incidents and accidents are used to implement improvements as indicated. The analysis includes the numbers of falls and the times that falls are occurring for residents who have had increased falls, with strategies implemented to reduce the number of falls.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance</p>	<p>FA</p>	<p>Professional qualifications and annual practising certificates (APCs) are validated on employment and annually. The service maintains a folder of current APCs which was sighted for all staff and contractors who require them.</p> <p>The staff files evidence that the appropriate employment processes are implemented, such as recruitment, interview and reference checking. After the orientation period there is a performance review conducted</p>

<p>with good employment practice and meet the requirements of legislation.</p>		<p>annually, as confirmed in the staff files reviewed. The manager has had a performance appraisal conducted within the past year.</p> <p>There is an orientation and induction programme all new staff complete, then role specific orientation for the different roles within the services. The initial general orientation includes the essential and emergency systems, handling concerns and complaints, cultural best practice, infection control, incidents/accident reporting, managing challenging behaviours and restraint minimisation. Each staff file reviewed evidenced an orientation and induction into their role. Staff reported that the orientation and induction gave them a good understanding of their role and responsibilities.</p> <p>The in-service education programme covers the essential components of service delivery for rest home and dementia level of care. The service also accesses ongoing education support from the DHB aged residential care programme, gerontology nurse specialists and palliative care services. The care staffing in the dementia unit meets contractual requirements for the required education related to the national unit standards for dementia care. Attendance records are kept for the education that staff have attended, as sighted in each of the staff member's personnel files.</p> <p>There are two RNs that are interRAI competent. The care staff who work in the dementia unit have either completed or commenced the required dementia specific training. The activities programme is overseen by an occupational therapist, with the other activities staff having experience in the support of residents with cognitive impairment, the activities staff are enrolled in diversional training and the management of residents with a diagnosis of dementia.</p> <p>Staff reported that they are supported and encouraged with maintaining their knowledge and skills.</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>	<p>FA</p>	<p>There is clearly documented policy on staffing levels and skill mix to meet the needs of residents requiring rest home and secure dementia level of care. There is at least one RN on duty during the day seven days a week and on call after hours. There are two caregivers, one RN and one activities staff on duty on morning shift in the dementia unit. There are at least two caregivers on site at all times and one staff member on call at all times during the night shift.</p> <p>There is at least one staff member on duty each shift who has current first aid qualifications. There is appropriate staffing level for activities, cooking, cleaning and laundry. Staff confirmed they have adequate time to do their required work and all staff assist in implementing meaningful activities for the residents throughout their shifts.</p>
<p>Standard 1.3.12: Medicine</p>	<p>PA</p>	<p>There is policy in place which describes the process to follow for residents who are deemed competent to self-administer medicines. At the time of audit there are no residents who self-administer their medications,</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>Moderate</p>	<p>no controlled drugs and no standing orders. There are improvements required in recording the medication fridge temperature and ensuring that all medication is signed as given (or reason recorded for withholding).</p> <p>With the exception of liquid medicines and stock medications, such as antibiotics, medicines are supplied by the pharmacy in a pre-packed administration system for individual residents. Medications are checked for accuracy by the RN when delivered. The pre-packed medicines and the signing sheets are compared against the medicine prescription. Regular medicine reconciliation processes are documented. Safe medicine administration was observed at the time of audit.</p> <p>The medicines and medicine trolley were securely stored in both the rest home and dementia units.</p> <p>All the medication files sampled had prescriptions that complied with legislation and aged care best practice guidelines. The GP has conducted medication reviews for all residents within the last three months.</p> <p>Medication competencies were sighted for all staff who assist with medicine management, this included the RNs and senior caregivers.</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>	<p>FA</p>	<p>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menus were reviewed by a registered dietitian in 2016 (and were under review at the time of audit) as being suitable for the residents at Pinehaven Cottage facility. The cook stated that food is produced in accordance with the menus. Food and snacks are available 24 hours a day. The kitchen has the dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents and family/whānau reported being satisfied with the meals and fluids provided.</p> <p>The kitchen is a domestic kitchen, with management reporting, and the business plan confirming, that the kitchen is planned for renovation in 2017. Food, fridge and freezer recordings are undertaken daily and meet requirements. There is a documented cleaning programme implemented. Kitchen staff have completed safe food handling training.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet</p>	<p>FA</p>	<p>The long term or short term care plans reviewed were individualised to show interventions put in place to contribute to meeting residents' goals. Information sighted on care plans is congruent with assessment findings. The interventions, such as meals and activities of daily living, were flexible to the needs of the residents.</p> <p>The residents and family/whānau interviewed reported that the staff have excellent knowledge and care</p>

their assessed needs and desired outcomes.		skills.
<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>	PA Low	Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. The activities staff stated that their role was to focus on giving the residents back some independence by focusing on activities that are meaningful. There are planned activities that covered physical, social, recreational and emotional needs of the residents (though this was not clearly documented for individual residents in the dementia unit). The activities programme is an evolving and flexible plan to match weather conditions and resident's abilities. Feedback received from the residents and family/whānau is taken into account when planning activities.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Evaluations are documented at least every six months. The evaluations indicate the degree of achievement or response to the support and/or interventions put in place towards the resident meeting their desired goals.</p> <p>Where progress was different from expected, the service responded by initiating changes to the care plan or by use of short term care plans for temporary changes. Short term care plans were sighted in the files reviewed.</p> <p>The residents and family/whānau interviewed reported high satisfaction with the care provided at the service.</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>The previous audit was conducted prior to completion of the dementia unit. The service still required to gain the required compliance certificates, furnish the unit, complete the fit out and complete the external access and landscaping. These were all addressed prior to occupancy of the dementia unit. A safe environment was observed at the time of this audit.</p> <p>The service has a current building warrant of fitness for the rest home and a code of compliance for the dementia unit.</p> <p>Hot water temperatures are monitored monthly; these are within safe guidelines. Medical equipment has annual calibration; last conducted within the last year. The electrical equipment is new or test and tagged within the last 12 months. The staff conduct a monthly compliance check of the environment.</p> <p>The environment promotes safe mobility, with secure hand rails in the hallways and floor surfaces that are intact and do not present a trip hazard. Each wing has access to the external areas. The dementia unit external area is separated from the rest home section of the service, though there is limited access to the external area from the dementia unit.</p>

		The residents and families reported satisfaction with the environment.
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>At the previous partial provisional audit, the fencing and security gating needed to be installed and the evacuations scheme required approval. These were addressed prior to occupancy of the dementia unit.</p> <p>There is an approved evacuation scheme that includes the recently addition of the secure dementia unit. The fire and emergency equipment has a monthly inspection as well as an annual certification by an external contractor. Emergency and security training is provided as part of staff orientation and ongoing in-service education. Evacuation drills are conducted six monthly. Staff demonstrated knowledge on how to respond in emergency or civil defence situations.</p> <p>The service has bottled gas for cooking and emergency lighting in the event of mains failure. There are water tanks and bottled drinking water that is accessible in emergency situations.</p> <p>Each room, toilet and bathing facility has access to a call bell. The call bell system has a light and audible alert when activated. Staff responded promptly when the call bell was tested.</p> <p>The layout of the dementia unit allows for residents with cognitive impairment to wander freely inside and into the secured external area. A night staff member has a checklist to ensure the entrances, doors and windows are secure. After hours' visitors are required to use the doorbell to gain access to the facility through the security gate in the driveway. This gate in the driveway has free access during the day. Staff, residents and families report satisfaction with the security arrangements.</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>Surveillance requirements are implemented to meet policy and standard requirements for the level of care offered at Pinehaven Cottage. Monthly infection control surveillance data is collected, recorded, reviewed, and analysed, with result discussed at the quality meeting. Standardised definitions of infections, which are appropriate to the long term care setting, are used. If an unexplained increase in infection rates is noted, corrective actions are taken. All data is shared with staff, management and the owner. Staff interviewed confirmed they understand the data results presented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are four residents who are assessed for enabler use (bed hoop) at the time of audit. The bed hoops do not limit the resident's freedom of movement and assist the resident to get in and out of bed. These are used at the request of the resident. There is no restraint use in the dementia unit, with a secure environment that support the resident with cognitive impairment to wander freely and safely.</p> <p>Policies evidence that enablers are voluntary and that the least restrictive option would be used with the</p>

		intention of promoting or maintaining resident independence and safety. The policies for restraint and enabler use are part of the orientation and induction training as well as in the ongoing in-service education programme. Staff demonstrated knowledge on restraint minimisation, the strategies used to minimise restraint and what to do if restraints or enablers were required.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</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,</p>	<p>PA</p> <p>Moderate</p>	<p>There is a medication fridge in the dementia unit, the temperature records were not evidenced at the time of audit. The manager and staff reported that the temperature is required to be recorded weekly, though this record was not located.</p> <p>Gaps where there was no signature or reason for not giving the medications were sighted in seven of the ten medication charts sampled. The signing sheet for non-pack medications for one resident did not evidence that the medication had been given for the previous three days. The reason for not giving a medication (the manager confirmed the resident had been in hospital) was not recorded for another resident. The staff member observed administration of the medication at the time of audit followed the correct process for medication administration and signing that the medications had been given.</p>	<p>The administration sheets in seven of the ten medication files sampled were not fully completed.</p> <p>The medication fridge does not consistently document the weekly temperature recordings.</p>	<p>Provide evidence that the medicines management systems for administration and storage consistently meet legislation and best practice guidelines.</p>

and guidelines.				90 days
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Low	<p>The service uses a mix of their own paper based assessment tools and the interRAI. All residents had a community interRAI, with this information used to form part of the organisation's admission assessment process. None of the files of the residents living in the dementia unit had a long term care interRAI that was conducted at Pinehaven Cottage. The files of the residents in the rest home had interRAI assessments that were conducted more than six months prior.</p> <p>The dementia unit was opened in November 2016. Two of the three files sampled of residents living in the dementia unit, did not have a long term care plan developed within the contractual three-week period. One of the files of a resident admitted in November 2016, still had a short term care plan and the long term care plan has not yet been developed. One other resident had their long term care plan developed two months' post admission. One resident had a long term care plan developed within the three-week period. All six residents' files did have sufficient detail in either the long term care plan or initial care plans to guide service provision. The residents and families all expressed high satisfactions in the interventions, skill and kindness of the staff.</p>	<p>Two of the three files sampled of residents living in the dementia unit did not have long term care plans developed within three weeks of admission.</p> <p>The three files sampled of residents living in the dementia unit did not have a facility conducted interRAI, and the three files sampled in the rest home interRAI assessments have not been conducted within the past six months.</p>	<p>Provide evidence that the timeframes for assessment and development of the long term care plans meet contractual requirements.</p> <p>180 days</p>
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are</p>	PA Low	<p>The activities programme is overseen by an occupational therapist with specific dementia training, who is also an assessor for the dementia unit standards. The activities staff who work in the dementia unit have either completed or are enrolled in a national qualification related to dementia or diversional therapy. There is an activities calendar that outlines the planned activities. The three files reviewed of the residents living in the dementia unit did not have an individualised plan that outlined the resident's needs over the 24-hour period. Activities observed on the day of audit were meeting the recreational and social</p>	<p>The individual resident's files in the dementia unit do not have a description of the activities that meet the resident's needs</p>	<p>Provide evidence that the activities plan for the residents living in the dementia unit meet</p>

<p>meaningful to the consumer.</p>		<p>needs of the residents, in the rest home and dementia unit. The activities team in the dementia unit are at the service at times to assist in diversional activities during the day and early evening (10.30 am and to 6.30pm), which staff have reported assist with minimising 'sun downing' and other challenging behaviours.</p>	<p>in relation to individual diversional, motivational, and recreational therapy during the 24-hour period.</p>	<p>contractual requirements.</p> <p>180 days</p>
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.