

G A & H J Lydford

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 HealthShare 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:	G A & H J Lydford
Premises audited:	Tarahill Resthome
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 28 April 2017 End date: 28 April 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:	17

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

G A & H J Lydford trading as Tarahill Resthome provides rest home level care for up to nineteen residents. On the day of audit there were 17 residents. The service is managed by the nurse manager who is also one of the two owners. The nurse manager has a current practising certificate with a scope limited to mental health. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Service Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed three of four shortfalls from the previous certification audit around professional qualifications monitoring including reference and police vetting; ensuring that care plans are updated as changes to care are identified; and stopping of nurse initiated medicine orders. Improvements continue to be required in relation to annual medicine administration competencies.

This surveillance audit identified that improvements are required in relation to the timing of interRAI assessments; and the medicine 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.
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Staff communicate effectively with residents and their families. The manager and staff are in constant communication with residents and relatives. Interpreter services are available if needed. There is a consumer complaints system in place. The numbers of recorded consumer complaints are minimal. Residents and relatives interviewed believed that staff respected their rights and that management responded promptly and appropriately to any matters of concern.

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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The organisation is governed by the two owners who set the goals for the organisation. The nurse manager who is one of the owners has a management plan in place, which outlines the philosophy and priority goals for the organisation. There is an established, documented and maintained quality and risk management system that reflects continuous quality improvement principles. All adverse events are recorded and reported to affected residents and their family in an open manner.

Human resource management processes are conducted in accordance with good employment practices. Professional qualifications are validated and police vetting occurs. New staff are orientated and there is ongoing training provided. Caregivers are encouraged to obtain additional qualifications. On the day of audit of the 12 caregivers employed, five caregivers had a level 3 or equivalent NZ Qualifications Authority (NZQA) recognised qualifications. Another four caregivers had completed ACE training years ago which is no longer recognised by NZQA. The nurse manager and the registered nurse and caregivers are required to

hold first aid certificates. On the day of audit six of 13 caregivers have current first aid certificates and these six are used as the senior caregiver on the roster or the nurse manager is on site. The relieving RN does not hold a current first aid certificate. When the relieving RN is on duty a senior caregiver who holds a current first aid certificate is on duty. The relieving RN is in the process of obtaining a current first aid certificate and first aid training for staff is booked for May 2017.

There is a policy around staffing. The rosters sighted reflect staffing levels that meet resident acuity and bed occupancy. The nurse manager or the relieving registered nurse are on call if not on site.

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>
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Residents are assessed by a registered nurse within 24 hours of admission. Additional specialised assessments are completed within required timeframes. InterRAI assessments are completed by a registered nurse however in all five care plans sampled the interRAI assessment was completed following the development of the resident's long term care plan.

Each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Plans of care are resident focused, accurate and up to date. Care plans are reviewed six monthly or earlier if necessary. The residents and family interviewed confirmed their input into care planning.

Each resident had access to an individual and group activities programme. Individual activities are provided either within group settings or on a one-on-one basis. The programme was run by the diversional therapist or caregivers on duty.

There is a system of medicines management in place. Policies and procedures partially reflect legislation and guidelines.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. The kitchen staff have completed food safety training.

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 has a current warrant of fitness, There have been no building alterations since the previous audit.

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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Restraint minimisation is practised and there are policies in place that describe the management of enablers and restraints. No residents were using enablers or restraints on the day of audit.

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.

The surveillance programme is included in the infection prevention and control programme. The nurse manager oversees the surveillance programme. The infection rate is low. There have been no outbreaks of infection in the period since the previous audit.

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	1	1	0	0
Criteria	0	37	0	1	3	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>Policy, procedures and forms are in place to support the resident's right to complain. The complaints management process meets the requirements of Right 10 of the Code and is explained as part of the admission process. Complaints management is part of the staff orientation programme and ongoing education. Residents and family confirmed that the management open door policy makes it easy to discuss concerns at any time.</p> <p>An up-to-date complaints register is maintained. The complaints register records the complaint, dates and actions taken. There were no outstanding complaints and there have been no complaints to external authorities since the last audit.</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>Open disclosure is practised by management and staff. Residents and relatives are kept informed regarding events that impact on the resident's care. Family members interviewed confirmed that they are informed if the resident has an incident, accident, or has a change in health or needs. Management maintain an open-door policy so that residents and families can contact them to discuss concerns at any time. All family contact is recorded in residents' files.</p> <p>Interpreting services are available from the district health board (DHB). There</p>

		were no residents requiring interpreting services at the time of the audit.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The facility is governed by the two owners who live in attached accommodation. One owner acts as the nurse manager (previously referred to in the certification report as the facility manager) and has been in the position for 21 years. The nurse manager is a registered nurse with a scope limited to mental health. The other owner takes on the role of maintenance for the facility and is not an employee. The two owners have owned the facility since May 2009. Both are on site during the weekdays and weekends and are supported by a registered nurse who provides between two to six hours' support per week. The diversional therapist acts as the second in charge to the nurse manager. The nurse manager has at least eight hours training relevant to the role, annually and has been trained in completing interRAI assessments.</p> <p>There is a management plan in place, which outlines the philosophy and priority goals for the organisation. The facility can provide care for up to 19 residents requiring rest home level of care. There were 17 residents at the time of the audit. Services are provided under the aged related residential care agreement.</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>	FA	<p>There is a quality improvement system in place which is understood by staff. The management plan and quality improvement plan are reviewed annually and enable the owners to track organisational performance. There are a range of policies, associated procedures and forms in place to guide staff practice. These documents are reviewed three yearly as outlined in policy.</p> <p>Key components of service delivery are linked to the quality and risk management system through the collection of quality related data (eg, data regarding incidents and accidents, hazards, complaints, health and safety, infection prevention and control and restraint minimisation.</p> <p>The nurse manager completes annual reviews of each aspect of service delivery using a monthly audit schedule to ensure that all audits and reviews are completed as required. The results of internal audits are communicated to staff and where appropriate information is shared with residents at the monthly resident meetings which family are able to attend. Corrective actions are identified as part of reviewing incidents and accidents and complaints or will arise from discussions with staff, residents or relatives.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service which have been updated to</p>

		<p>reflect the change in legislation. Health and safety checks occur continuously and there is a health and safety representative on site. There is a hazard register in place.</p> <p>Resident satisfaction levels are monitored throughout the year. Residents and relatives interviewed were very satisfied with the cares provided.</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>	FA	<p>The nurse manager is aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks. There have been no events requiring external reporting since the previous audit.</p> <p>There is an established system in place for staff to document all incidents, and accident reporting. Corrective actions are identified as part of the review of the event. Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>Incidents reports were sampled. There were a minor number of incidents. Incident reporting and management was consistent with the organisations policy. Corrective actions were identified where appropriate. Data was collated and reported. There was evidence of open disclosure occurring with families.</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>The policy in place to guide human resource practices meets current legislation and good employment practice. Management appoint staff to meet the needs of residents.</p> <p>Professional qualifications are validated for both registered nurses and visiting health practitioners. Reference checks occur before appointment and police vetting of all newly appointed staff is completed. The previous shortfalls regarding validation of qualifications, police and reference checks have been addressed.</p> <p>New staff receive an orientation on commencement. A record of orientation is maintained. Ongoing education is provided and there is an annual training plan in place. There is an expectation by management that caregivers will complete health and disability sector related NZ Qualifications Authority (NZQA) qualifications. On the day of audit of the 12 caregivers employed, five caregivers had a level three or equivalent NZQA qualifications. Another four caregivers had completed ACE training.</p>

		<p>There is a staff member with a current first aid certificate on each duty. Mandatory competencies include the administration of medications. This was a previous shortfall for which improvements continue to be required and has been documented in standard 1.3.12.</p> <p>Performance appraisals occur.</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>There is a policy around staffing, which is the foundation for work force planning. Rosters sighted reflect staffing levels that meet resident acuity and bed occupancy.</p> <p>The nurse manager is on call if not on site. A registered nurse with a current practising certificate is employed as a reliever for two to six hours a week and is available on call every second weekend. Staff confirmed that the nurse manager or registered nurse is available at any time and they respond immediately if required.</p> <p>There are 17 staff including the nurse manager, the relieving RN, the diversional therapist, two cooks and 12 caregivers. The other owner is not an employee but is responsible for maintenance. Residents and families confirm staffing is more than adequate to meet the residents' needs and residents and family members praised the staff and nurse manager as providing a resident focused service.</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>	PA Moderate	<p>There is an established medicines management system in place. There is policy in place to guide practice. The caregiver administering the lunchtime medicines was witnessed.</p> <p>The medicine management policy identifies that staff who administer medicines must be competent; however, competencies have not been maintained as required. This is a previous shortfall which is yet to be addressed.</p> <p>Medicine administration charts are produced and supplied by the dispensing pharmacies. The nurse manager or registered nurse checks the medication packs when received from the pharmacy.</p> <p>The previous short fall regarding nurse initiated medicines has been addressed and standing orders are no longer used.</p> <p>Medicines are stored securely.</p> <p>There is a process for the managing the safety of residents who self-administer their medications. This process requires an improvement to maintain resident</p>

		<p>safety.</p> <p>Medicines charts were sampled which showed that documentation and storage did not consistently meet current best practice guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The rest home uses a summer/winter seasonal menu which has been reviewed by a dietitian in 2015. Nutritional guidelines for older people are available and considered when the menu plans are developed. The evening meal is served as the main meal and residents stated that they preferred this option.</p> <p>An individual dietary assessment (nutritional status) is completed on admission for all residents which identifies individual needs and preferences. Morning and afternoon teas are prepared in the kitchen and snacks are available over twenty-four hours. Residents are weighed on admission and monthly thereafter unless there is a clinical indication for more frequent monitoring. The food service is managed by two cooks over seven days. Special diets can be arranged.</p> <p>All staff have completed relevant food safety certificates. The cooks are supported by management with the ordering and purchasing of food supplies and they are able to describe individual requirements of the residents. Foods are stored above floor level and the refrigerators and freezers are monitored on a daily basis. There were no very low weight residents requiring special cares.</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>Residents' care plans evidence interventions, individual desired outcomes or goals.</p> <p>Each resident has their own general practitioner (GP). Most residents are seen at their GP's practice. There is a record of the GP visit included in each resident's clinical record. GPs review residents every three months or earlier if required. Residents and family confirmed that resident's current care and treatment meets their needs. Family communication is recorded in the residents' files.</p> <p>Residents receive services that align with accepted practice with the exception that interRAI assessments are not completed prior to the development of the resident's long term care plan, however interRAI assessments were completed within 21 days of admission and completed six monthly.</p> <p>Short-term care plans are developed, when required and signed off by the nurse manager or the relieving RN. They record the detail of information required. Progress against the short-term plan is recorded in the progress notes.</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>A diversional therapist (DT) is employed for 30 to 40 hours per week to implement the individual and group activities programme. The programme is planned with the residents having input through the resident meetings and on a one to one basis. The activities programme is displayed on a weekly/monthly calendar with individual assessments and plans documented by the diversional therapist. The diversional therapist completes monthly documentation of participation and there is a daily attendance register kept for each resident. Caregivers also support activities according to the activities programme when the DT is not present. Assessments and plans with evidence of review was sighted in all resident files reviewed.</p> <p>Each resident has an individual activity plan and may choose to participate in either the group programme or elect to follow their individual interests. Staff support the resident's choice. Residents reported they are happy with the activities provided.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are conducted at least six monthly or earlier if warranted or requested. Evaluations are documented in interRAI and indicate the degree of achievement or response to the resident's goals. Residents and family confirm their participation in care plan evaluations.</p> <p>The residents' progress records are entered in daily. When resident's progress is different from expected, the RN documents changes in the care plan. The previous short fall regarding updating of care plans has been addressed. There was evidence that in the event changes in the resident's condition had occurred outside of the six-monthly review period care plans had been updated as required. All care plans reviewed accurately reflected the resident's health status.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness that expires 17 June 2017. No building alterations have occurred since the previous audit</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</p>	<p>FA</p>	<p>The infection prevention and control coordinator is the nurse manager who is responsible for the surveillance programme. Monthly surveillance data relating to number and type of infections are recorded and there is evidence the data being analysed and evaluated. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Staff report they</p>

programme.		are made aware of any infections of individual residents by way of feedback from the nurse manager or registered nurse, through verbal and written handovers and through documentation in progress notes. The infection rate is low. There has been no outbreaks of infection since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures on restraint minimisation and use of enablers are documented and there are links with the policy for managing challenging behaviour. These are accessible to guide staff actions related to restraint and enabler use.</p> <p>On the day of audit there were no residents using enablers or restraints. The nurse manager is the restraint co-ordinator.</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 1.3.12.1</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>Each resident had two sets of medicine orders. One set (the master chart) is stored in their clinical record and the other set (which was described as a copy of the master chart) is stored in the medicines charts folder which was used by staff to administer medicines. The chart in use has been developed by the rest home and has not been generated by the dispensing pharmacy. A review of both charts for the sample of 10 residents revealed inconsistencies between 7 of 10 sets of medicine orders.</p> <p>All ten medicine orders are typed by the nurse manager and then signed by the resident's GP. This is a systemic practice for all residents.</p> <p>One resident's medicine (on their master chart) had been signed by the nurse</p>	<p>Medication management documentation and storage do not meet the practice guidelines for residential aged care.</p>	<p>Ensure medicines are managed according to the Medicines Care Guides for Residential Aged Care.</p> <p>60 days</p>

		<p>manager on the resident's medicines order as discontinued. The copy medicine order had been signed by the GP as discontinued</p> <p>One medicine chart in use was prescribed for the wrong resident. Page one of the order was correct but page two was not and listed the medicines belonging to another resident.</p> <p>As needed medicines were not clearly documented by the GPs in the charts sampled. Specific target symptoms were not listed; the instruction(s) for the use of the medicine was not documented and the indication of how long as needed medicines could be given was not stated.</p> <p>Each of the 10 residents had a photo on their medicines order however the photos were not dated.</p> <p>One resident was charted an alternative 'over the counter' medicine by their GP a few months ago on the master order. There was no record of the order being administered by staff.</p> <p>Medicines requiring refrigeration were not stored in a secure designated refrigerator (i.e. injectable insulin, eye drops and other medicines). Medicines were being stored in an unsecure refrigerator which was being used to store additional food and fluids.</p> <p>Any allergies or sensitivities are documented on the medicine order but these are typed by the nurse manager and not documented by the resident's GP.</p> <p>There was no evidence sighted that residents have been harmed through the</p>		
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		practices related to medicines management.		
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>The policy identifies that staff who administer medicines must be competent. The senior caregiver on each shift is required to be competent to administer medicines to residents. The previous certification audit identified that the nurse manager and the RN had not completed annual medicine competencies. Since the previous audit the nurse manager's competency had been assessed and was signed off by the diversional therapist, and not a competent RN as required.</p> <p>The nurse manager had reviewed the competencies of caregivers as well as the relieving RN. Further improvements are required for medicines competencies to meet the Medicines Care Guides for Residential Aged Care.</p>	<p>Medication competencies have not been maintained as required in the practice guidelines for residential aged care.</p>	<p>Maintain medicines administration competencies are completed as required.</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 Moderate</p>	<p>One resident self-administering their eye drops did not have a capacity assessment in place which was reviewed three monthly; had not signed an agreement regarding their responsibilities for safety; their medicines chart was not marked that the resident was self-administering this medicine; there was no evidence that staff had checked with the resident each shift as to whether the resident had administered the eye drops; and storage of the eye drops was in an unsecured refrigerator located in the dining room..</p> <p>One resident was self-administering one of their medicines on the day of audit. Their remaining medicines were administered by staff.</p>	<p>The self-administration process has not been completed as required in practice guidelines for residential aged care.</p>	<p>Ensure residents who are self-administering medicines are managed according to the requirements of the Medicine Care Guides for Residential Aged Care.</p> <p>30 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>Each resident is assessed on admission by the registered nurse and an immediate plan of care developed. The resident is then assessed by the registered nurses and caregivers. A long-term care plan is developed within 21 days of admission however an interRAI assessment had not been completed prior to the development of the care plan in the resident files sampled.</p>	<p>The required InterRAI assessments had not been completed prior to the development of long term care plans in the residents records sampled.</p>	<p>Complete interRAI assessments prior to the development of the resident's long term care plan.</p> <p>90 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.