

Presbyterian Support Central - Kilmarnock Heights

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: Presbyterian Support Central

Premises audited: Kilmarnock Heights

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 17 August 2015 End date: 17 August 2015

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 32

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

Kilmarnock Home is owned and operated by the Presbyterian Support Central and cares for up to 40 residents requiring rest home level care. On the day of the audit there were 32 residents. The manager is well qualified and experienced for the role. Residents, relatives interviewed, spoke positively about the service provided.

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

Two of the two shortfalls identified at the previous audit have been addressed. These were around pain assessments and aspects of medication documentation.

This audit has identified further improvements required around meeting ARC contract timeframes 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.

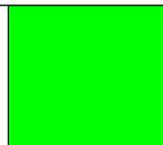


Standards applicable to this service fully attained.

The service ensures effective communication with all stakeholders including residents and families. Complaints processes are implemented and complaints and concerns are managed and documented.

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.

Kilmarnock continues to implement the Presbyterian Support Services quality and risk management system that supports the provision of clinical care. Key components of the quality management system link to a number of meetings including monthly senior team meetings. An annual resident satisfaction survey is completed and there are regular resident meetings. Quality performance is reported to staff at meetings and includes a summary of incidents, infections and internal audit results. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has an induction programme that provides new staff with relevant information for safe work practice. There is an organisational training programme covering relevant aspects of care and support. The staffing policy aligns with contractual requirements and includes skill mixes.

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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Registered nurses are responsible for each stage of service provision. The residents' needs, objectives/goals have been identified in the long-term support plans and these have been reviewed at least six monthly or earlier if there was a change to health status. Resident and/or family/whānau have input into care planning and the six monthly reviews. Resident files are integrated and include notes by the GP and allied health professionals.

The activity programme is resident-focused and provides group and individual activities planned around everyday activities. There are strong community links including volunteers that assist with activities.

There are medicine management policies and procedures in place. Medication is managed in line with current guidelines. The medication charts are reviewed by the GP three monthly.

Food is cooked onsite. A contracted dietitian reviews the menus. Food services staff are aware of resident's likes/dislikes and alternative choices are offered.

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 building warrant of fitness and maintenance is carried out.

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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The service currently has a restraint-free environment. The service has policies and procedures to support the use of enablers and restraint. Education is provided annually to staff.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

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	15	0	1	1	0	0
Criteria	0	37	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>There is a complaints policy to guide practice and this is communicated to resident/family. The facility manager leads the investigation and management of complaints (verbal and written). There is a complaints register that records activity. Complaints are discussed at the monthly senior management team meeting and at the staff meetings. Complaint forms are visible around the facility on noticeboards. There were six documented complaints in 2015. There were no complaints in 2014. Follow up letters, investigation and outcomes were documented. Discussion with residents and relatives confirmed they were aware of how to make a complaint. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>The service has an open disclosure policy. Discussions with six residents and two family members confirmed they were given time and explanation about services and procedures on admission. Resident meetings occur bi-monthly and the facility manager and clinical nurse manager have an open door policy.</p> <p>Accident/incident forms have a section to indicate if family have been informed (or not) of an accident/incident. Thirteen accident/incident forms reviewed August 2015 identify that family were notified following a resident incident. Interview with four health care assistants (HCA) and one clinical nurse manager (RN) confirmed that family members are kept informed.</p> <p>The residents and relatives interviewed confirmed family have been informed when the resident health status</p>

communication.		<p>changes. The service has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit. The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement. The information pack is available in large print and advised that this can be read to residents.</p> <p>Five resident admission agreements sighted were signed and completed within the required timeframe. The admission agreement contains a schedule of fees and charges where applicable. Residents and relatives interviewed confirmed the admission process and agreement were discussed with them and they were provided with adequate information on entry.</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>	FA	<p>Kilmarnock Heights Rest Home is part of the Presbyterian Support Central organisation (PSC). The service provides rest home level of care for up to 40 residents. On the day of the audit there were 32 rest home residents including one respite resident. Kilmarnock has a 2015-2016 business plan and a mission, vision and values statement defined. The business plan outlines a number of goals for the year, each of which has defined objectives against quality, Eden and health and safety. Progress towards goals (and objectives) is reported through the facility manager reports taken to the monthly senior management team meeting, and discussed at staff meetings. The facility manager is supported by a relieving clinical nurse manager (CNM). A newly appointed clinical nurse manager has commenced. She is currently completing induction with the relieving CNM.</p> <p>The manager has a certificate in management studies and has been in the role for the last 4.5 years. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.</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</p>	FA	<p>PSC has an overall Quality Monitoring Programme (QMP) and participates in an external Quality Performance Systems (QPS) quarterly benchmarking programme. The quality system continues to be well implemented at Kilmarnock. The monthly and annual reviews of this programme reflect the service's ongoing progress around quality improvement. There is a senior team meeting that meets twice a month. Information is fed back to the staff meetings. A range of other meetings are held at the facility. Meeting minutes and reports are provided to the quality meeting, actions are identified in minutes and quality improvement forms which are being signed off and reviewed for effectiveness.</p> <p>Feedback on monthly accident and incidents are provided at all meetings. The service has linked the complaints process with its quality management system, including QPS benchmarking programme and feedback through the quality and staff meetings. There is an infection control register documenting monthly activity. A monthly infection control statistics are completed and provided to senior team meeting. Infections are also being documented on an electronic database. Feedback is provided to staff through memos that include outcomes and improvements. The</p>

<p>principles.</p>		<p>service has a health and safety management system and this includes a health and safety rep that has completed health and safety training. Monthly reports are completed and reported to meetings and at the quarterly health and safety committee. Health & Safety meetings include identification of hazards and accident/incident reporting and trends. Emergency plans ensure appropriate response in an emergency.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards. A document control system is in place.</p> <p>Annual resident and relative satisfaction surveys have been completed as per company schedule which included an analysis. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management.</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>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The data is linked to the service benchmarking programme and this is able to be used for comparative purposes with other similar services. Quality and staff meeting minutes include a comprehensive analysis of incident and accident data and corrective actions. A monthly incident accident report is completed which includes an analysis of data collected. This is provided to staff. Thirteen accident/incident forms reviewed for August 2015 included registered nurse assessment and follow up.</p> <p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice</p>	<p>FA</p>	<p>There are human resource management policies in place, which includes recruitment, and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed one clinical nurse manager, one RN and three HCA's. Each folder had a file checklist and documentation arranged under personal info, correspondence, agreement, education and appraisals. Annual appraisals have been completed and up to date. The service has in place a comprehensive orientation programme that provides new staff with relevant information for safe work practice. This was described by staff and records were sighted.</p> <p>The in-service education programme for 2015 is being implemented. The majority of HCA's have completed an aged care education programme. Staff attend an annual compulsory study day which includes training around the</p>

<p>and meet the requirements of legislation.</p>		<p>Eden Alternative programme. The clinical nurse manager and RN are able to attend external training. Eight hours of staff development or in-service education has been provided annually. All individual records and attendance numbers are maintained on-line. Monthly reporting of training completed and staff attendance, is reported to the regional manager monthly. There is a first aid trained staff member on every shift</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse manager work full time, Monday through Friday. There is a part time registered nurse that works Saturday and Sunday. Care staff have access to a RN via a PSC on call roster. Extra staff can be called on for increased resident requirements. Interviews with four HCA's, six residents and two family members identify that staffing is adequate to meet the needs of residents.</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>Click here to enter text</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>There are policies and processes that describe medication management that align with accepted guidelines. An RN checks all medications on delivery. Any discrepancies are fed back to the supplying pharmacy. The RNs, and senior HCA's administering medications undergo a medication competency. Annual medication training is completed.</p> <p>The medication trolley is kept in the locked treatment room. There are two self-medicating residents who have completed their competency to self-administer medication; however these are not reviewed three monthly.</p> <p>Ten resident medication charts sampled identified all charts had photo identification and allergies/adverse reactions noted. Not all PRN medications prescribed had indications for use documented. One regular suspension</p>

		<p>was not being individually signed for when being administered. Not all eye drops in use were dated on opening.</p> <p>The 10 medication charts included three monthly GP reviews. All medication signed as given was charted, and this is an improvement since previous audit.</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>Food services policies and procedures manual is in place. There is a cook and five kitchen hands in total.</p> <p>There is a five weekly summer and winter menu that is reviewed by an external dietitian. The senior cook receives peer support, when all the PSC senior cooks meet annually. All residents have a dietary requirements/food and fluid chart completed on admission. The cook maintains a folder of resident's dietary requirements that include likes/dislikes. Alternative choices are offered. The cook is informed of dietary changes and any residents with weight loss. Dietary needs are met including normal, soft or pureed meals. Specialised utensils and lip plates are available as required.</p> <p>Daily food temperatures are taken on cooked food for all meals. Temperatures are taken on delivery for frozen foods, milk and cream. Fridge, freezer and chiller temperatures are recorded daily. All perishable foods are dated.</p> <p>The main kitchen area is well equipped. The dry goods are sealed, labelled and off the floor in the pantry. Safety data sheets are available and training provided as required. The service receives feedback directly from the residents, residents meetings, internal audits and resident satisfaction surveys. There is good communication between the food services and the clinical areas and the cooks are informed of any resident's dietary changes. Residents interviewed spoke positively about the food choice and variety of meals.</p> <p>Staff have been trained in safe food handling, chemical safety and other relevant in-service.</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>	FA	<p>When a resident's condition alters, the registered nurses initiate a review and if required, GP or specialist consultation. Two residents have recently been referred for reassessment. STCPs were comprehensively utilised in files reviewed for acute changes in health status.</p> <p>Dressing supplies are available and a treatment room/wound trolley is well stocked. All staff report that there are adequate continence supplies and dressing supplies. There are adequate pressure area resources. A health status summary held in the resident's record, records any significant events, investigations, GP visits and outcomes.</p> <p>There are three wounds currently being dressed (pressure area on heels, chronic leg ulcers and a finger wound). Wound assessment, care plans and treatment records were reviewed. There was evidence of the wound care specialist nurse being involved with the chronic, non-healing wounds.</p> <p>Monitoring charts are utilised for residents at risk. Fluid input/output charts were sighted for three residents. Food</p>

		input charts were in place for five residents including residents with identified weight loss. Three behaviour monitoring charts were currently in use. Pain assessments were sighted in the file of two residents with identified pain and this is an improvement since previous audit.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are two recreational officer's providing activities across five days. Volunteers also assist and also provide extra activities across the weekend. The programme is resident focused and is planned around everyday activities such as gardening, baking, reminiscing and household chores. Community links are maintained with inter-home visits, and children's visits from the school and kindergarten. Theme days, festive occasions and cultural celebrations occur. Church services are held on site weekly. Outings and drives are arranged in consultation with the residents to places of interest. There are a number of volunteers involved in the service that provide one on one activities, musical entertainment, church visitors and SPCA visitors and pets.</p> <p>The Eden philosophy principles of resident involvement and inclusion in their recreation activities within a home environment, is evident. There is a resident voted onto the Eden Committee. The recreational support plan is individualised.</p> <p>The wings in the facility have been given street names and are called "neighbourhoods". Each neighbourhood of residents have a weekly Catch up Cuppa with the recreational officer and management. The neighbourhood groups suit residents who prefer to socialise in smaller groups. Residents participate in everyday activities such as tending to the internal courtyard gardens, feeding the resident cats, birds and fish.</p> <p>Residents and relatives interviewed spoke positively about the activities programme and stated there was a lot of choice.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The files sampled evidenced six monthly evaluations of the support plan (link 1.3.3.3). Evaluations identified reviewing progress to meeting individual goals. The resident/family interviewed advised that they are notified of the reviews and invited to attend. The long term support plans reviewed evidenced that the support plan was amended with each review if there were changes identified. Short term care plans reviewed were evaluated regularly with problems resolved or added to the long term support plan if an on-going problem.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an</p>	FA	<p>The building holds a current building warrant of fitness, which expires 13 June 2016.</p> <p>PSC Kilmarnock Heights home is a 40 bed rest home complex divided into five wings (neighbourhoods) Rata Lane, Kowhai Close, Kauri Place, Totara Tce and Rimu Glen. Each neighbourhood has its own tea/coffee making</p>

<p>appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>facility.</p> <p>The physical environment with wide corridors and spacious rooms allow easy access, movement and promotes independence for residents with mobility aids. Handrails are appropriately placed in the corridors and communal areas. There is a large communal dining, recreational room, lounge areas and smaller areas for quiet activities, private meetings with family/visitors. There has been no building alteration since previous audit.</p> <p>The maintenance person is contracted for eight hours a week to carry out minor repairs and maintenance, external building maintenance and any internal maintenance and cleaning duties as per the schedules. The FM checks the daily maintenance request and co-ordinates the repairs. There are adequate storage areas for hoist, wheelchairs, products and other equipment.</p> <p>The grounds are tidy, well maintained and able to be accessed safely. Ramps are in place for wheelchair access to the outdoors. There is seating and shaded areas available. There is an internal courtyard. Residing cats, birds and fish add to the home like environment for the residents. There is a smoke room with an automated fan available for smoking residents.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources, and education needs within the facility.</p> <p>Internal infection control audits also assist the service in evaluating infection control needs. The service utilises an external benchmarking programme. Analysis of infection stats is completed on a quarterly basis.</p> <p>Infection control data is collated monthly and reported to the senior team meeting. The meetings include the monthly infection control report and quarterly benchmarking results.</p> <p>All infections are documented on the infection monthly on-line register. The surveillance of infection data assists in evaluating compliance with infection control practices.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There is a restraint minimisation and safe practice policy that is applicable to the service that has recently been updated by the organisation. The aim of the policy and protocol is to minimise the use of restraint and any associated risks.</p> <p>The service currently has a restraint-free environment. There are currently no residents using enablers at Kilmarnock Heights.</p> <p>There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0.</p>

		Restraint/enabler and challenging behaviour training has been provided.
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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, and guidelines.</p>	<p>PA Moderate</p>	<p>The service has monthly robotic packs. There is a locked treatment room. The supplying pharmacy delivers all pharmaceuticals, monthly regular robotic packs. The returns are stored safely until collected. The CD register had been completed as required. A review of 10 medication charts and the medication stored in the medication trolley identified documented shortfalls.</p>	<p>(i) Four of six medication charts that included PRN medications, did not have documented ‘indications for use’. (ii) One regular suspension was not being individually signed for when being administered (this was addressed pre-audit by changes in signing sheets). (iii) Two eye drops currently in use were not dated on opening.</p>	<p>(i) Ensure all PRN medication has ‘indications for use’; (ii) Ensure all medication not included as part of a robotic pack are individually signed for; (iii) Ensure all eye drops are dated on opening.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by</p>	<p>PA Low</p>	<p>There are two residents self-medicating. The medication policy describes the responsibilities for self-medicating documented. Medication is stored in the</p>	<p>Two self-medicating residents do not have their competencies reviewed three monthly.</p>	<p>Ensure competencies are reviewed three</p>

consumers where appropriate.		treatment room and the resident is observed taking their medication. Competencies reviewed for the two residents self-medicating did not identify three monthly reviews.		monthly. 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>There is a resident admission respite policy and the respite support plan and care plan template and checklist. The respite resident had all documentation including initial care plan completed on admission.</p> <p>In all five files reviewed the clinical nurse manager or registered nurse had completed an initial assessment within 24 hours. Three of four long term support plans had been completed within the required time frames. Three of four long term care plans had six monthly documented evaluations.</p> <p>Reassessments tools including (but not limited to) falls risk, pressure risk, nutrition risk had been completed three monthly.</p> <p>The newly appointed clinical nurse manager is in the process of commencing implementing InterRAI assessments.</p>	<p>Two of five resident files did not meet ARC contract timeframes; (i) one LTCP did not include a six monthly care plan evaluation; (ii) one LTCP was not established within 21 days from admission</p>	<p>Ensure documentation meets the required ARC contract timeframes.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.