

# Radius Residential Care Limited - Radius St Joans Hospital

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## 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:** Radius Residential Care Limited

**Premises audited:**

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Intellectual; Residential disability services - Physical; Residential disability services – Sensory

**Dates of audit:** Start date: 21 April 2015 End date: 22 April 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:** 0



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Radius Waipuna is part of the Radius Residential Care Group. Radius Waipuna provides care across three service levels (hospital, rest home and residential disability – physical level care) for up to 58 residents. On the day of the audit there were 49 residents. The facility manager and clinical manager (both registered nurses) are new to the service since previous audit. They both have previous experience in aged care.

This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This 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.

There have been a number of improvements to the environment since previous audit including re-decorating of bedrooms, upgrading of bathrooms and new furniture.

The service has addressed five of six shortfalls from their previous certification around EPOA's, neurological observations, aspects of care planning, transcribing and discontinued medications, facility upgrade and external pathways and gardens. An improvement continues to be required around pain assessments.

This audit identified an improvement required around the documentation of interventions to reflect the resident's current needs and stock medication checks.

## 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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Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaints process is made available to residents/family the time of admission and is available in the entranceway. All concerns and complaints have been managed appropriately. The complaints register is up-to-date. Residents and families interviewed state they are kept informed on all health related matters. The previous finding around copies of EPOA on residents file has been addressed.

## 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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Radius Waipuna is part of the Radius group and as such, there are organisational wide processes to monitor performance. The service is managed by appropriately trained personnel. There is a quality system that is being implemented in line with the business plan. Quality/staff meetings are used to monitor quality activities such as internal audits, complaints/concerns, health and safety, infection control and restraint. There is an adverse event reporting system implemented at Radius Waipuna and monthly data collection monitors predetermined indicators. There is a human resource manual to guide practice. There is an annual education programme which covers mandatory requirements. There is a documented rationale for staffing the service. Staffing rosters were sighted and residents, families and staff confirm there are adequate staff on duty.

## 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. Initial assessments and care plans were developed within the required timeframes. The sample of residents' records reviewed provided evidence that the provider has systems to assess, plan and evaluate care needs of the residents. The residents' needs, interventions, outcomes/goals have been identified and these are reviewed with the resident and/or family/whanau input. Care plans are reviewed six monthly. There is a requirement to document interventions to reflect the resident's current needs.

Medication documentation and policies reflect legislative requirements. Education and medicines competencies are completed by staff responsible for administration of medicines. The previous finding around transcribing and discontinuation of medications have been addressed.

The activities programme provides varied options and activities that meet the abilities of each consumer group. Each resident has an individualised plan. Community activities are encouraged and van outings are arranged. Resident files include notes by the general practitioner and allied health professionals.

All food is cooked on site by the cook. The menu has been reviewed by a dietitian. All residents' nutritional needs are identified, documented and choices provided. Food and fridge temperatures are recorded.

## 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 has been ongoing upgrading of bathrooms and bedrooms. The external areas and gardens are well maintained. The previous findings around facility upgrade and maintenance of external areas has been addressed.

## 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 has policies and procedures to appropriately guide staff around consent processes and the use of enablers. There are currently three residents using enablers and three residents using restraint. Staff receive training in restraint and managing challenging behaviour as part of the annual training plan.

## 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.

There is an infection control policy that includes surveillance activities. Infections are reported and collated monthly. Infections and internal audit outcomes are discussed as part of the quality/staff meetings. Information is available to staff. The surveillance programme is appropriate to the size and complexity of the facility.

## 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)
<b>Standards</b>	0	16	0	1	2	0	0
<b>Criteria</b>	0	41	0	1	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Five of five resident files sampled (one rest home, one young disabled and three hospital) evidenced a copy of the enduring power of attorney. The previous finding at certification audit has been addressed.</p>
<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 policy to guide practice which aligns with Right 10 of the Code. The Privacy Officer (manager) leads the investigation of non-clinical and clinical concerns/complaints. There is an up-to-date complaints register. There have been three verbal and five written complaints in the last year. Appropriate action has been taken within the required timeframes and to the satisfaction of the complainants. Complaints forms are visible. Management operate an “open door” policy. Families and residents (two hospital and two rest home) confirm they are aware of the complaints process and management are approachable.</p> <p>D13.3h. 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 communication.</p>	<p>FA</p>	<p>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been informed of an accident/incident. Eight of eight accident/incident forms reviewed for January 2015 identify family were notified following a resident incident. The clinical manager and facility manager confirm family are kept informed. Family interviewed (two hospital and two of younger person with disability) confirm they are notified promptly of any incidents/accidents. There is access to an interpreter services. Two monthly resident meetings are held. Meeting minutes sighted evidence residents are kept informed on facility matters, health related matters including education as appropriate and are encouraged to discuss any concerns and provide feedback on services.</p> <p>D12.1: Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii: 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</p> <p>D16.4b: There is documented evidence of family notification when their relatives health status changes.</p> <p>D11.3: The information pack is available in large print and this can be read to residents</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>Radius Waipuna rest home and hospital provides care for up to 58 residents. There are 43 dual service beds and 10 residential disability beds. On the day of audit there were five rest home level, 34 hospital level and 10 residential disability residents. Seven of 34 hospital resident were under the medical component of certification.</p> <p>Radius has an organisational philosophy, which includes a vision and mission statement. There is a strategic business plan for 2014 – 2017 that has had an annual review.</p> <p>The registered nurse (RN) manager has a background of 14 years in aged care management roles and has completed a post graduate paper in mental health. She was appointed the manager of Radius Waipuna in July 2014. The clinical manager/RN has four years aged care experience and was appointed to the role in October 2014. Both managers are also supported by a regional manager (RN).</p> <p>ARC,D17.3di (rest home), D17.4b (hospital), the manager has maintained at least eight hours annually of professional development activities related to managing a hospital.</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>Radius Waipuna has implemented a quality and risk management system. Radius Waipuna has a site specific quality plan which includes on-going refurbishments of bedrooms and bathrooms and the proposed plan for a new extension with shared ensuites. The quality plan has a visual version that is displayed for staff. This is known as the “radius bus journey in all we do” to achieve the Radius vision which is: to continuously improve the quality of our services to be leaders in care. Quality improvements implemented in 2014 includes the installation of new call bell system and staff training. Quality initiatives in progress are the falls project plan in conjunction with the district health board (DHB) and introduction of communication/English courses for staff with English as a second language.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. Staff interviewed (one RN and two healthcare assistants – HCA’s) confirm they are made aware of new/reviewed policies.</p> <p>There are monthly quality/staff meetings where monthly quality data is discussed including infections, accidents and incidents, health and safety, restraints and enablers, concerns and complaints and audit outcomes. RN meetings are held monthly. Health and safety and infection control is included in the quality/staff meetings. Support services meetings alternate every second month. Special meetings are called as required. Meeting minutes were sighted. Staff interviewed confirm meeting minutes are available and quality data is displayed for their information.</p> <p>There is an internal audit programme that includes clinical and non-clinical audits. For audits with outcomes below 95% a corrective action is raised and re-audits occur within a month. Annual resident/relative satisfaction surveys are completed annually in July. Results were collated and fed back to participants through resident meetings. A meal survey was completed in August 2014.</p> <p>Benchmarking of quality indicators occurs within the Radius organisation. The Radius Waipuna facility receives feedback on its performance through the Radius on-line quality system.</p> <p>D19.3: There is an implemented Health and safety and risk management system in place including policies to guide practice. The service have two health and safety representatives who have attended relevant training. There is a current hazard register that is due for review July 2015.</p> <p>D19.2g: Fall prevention strategies were in place that include the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Falls risk assessments are completed. Interventions include sensor mats, physiotherapist assessments and post falls assessments.</p>
<p>Standard 1.2.4: Adverse</p>	<p>FA</p>	<p>Nine accident/incident forms for the month of January 2015 were sampled. There has been RN notification</p>

<p>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>and clinical assessment completed within a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whanau had been notified.</p> <p>The service collects incident and accident data and reports aggregated figures monthly to the quality/staff meeting.</p> <p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.</p> <p>Discussions with the manager, confirms 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 and meet the requirements of legislation.</p>	FA	<p>There are human resources policies to support recruitment practices. Five staff files sampled contained all relevant employment documentation including reference checks and completed orientations with relevant information for safe work practice. Current practising certificates were sighted for the manager, clinical manager, RNs and allied health professionals. Staff interviewed believed new staff were adequately orientated to the service on employment. Performance appraisals are up to date.</p> <p>The 2014 annual education planner covered all the compulsory training requirements. The 2015 education sessions have commenced. Additional sessions and toolbox education at handovers ensure all staff receive training. Visual learning and English tutoring has been implemented to improve staff learning and communication where required. The manager and clinical manager have completed InterRAI training.</p> <p>Clinical staff complete competencies and questionnaires' relevant to their role including medication competencies.</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>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. There is a clinical manager Monday to Friday with shared on call with the manager (RN).</p> <p>There is an RN 24/7. The diversional therapist works Monday to Friday. There are dedicated cleaning, laundry and food services staff. The HCA's, residents and relatives interviewed inform there are sufficient staff on duty at all times.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Low	<p>Overall medication documentation identifies that medication is managed appropriately in line with required guidelines and legislation. RNs only administer medications and have completed education and</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>competencies. One self-medicating resident has been competency assessed and monitored regularly. There were no standing orders. Medication fridge temperatures have been checked weekly. Two glucagon kits were found to be expired and replaced on the day of audit. There was no evidence of transcribing of 'as required' medications and all signing sheets and medication charts sampled were correct. This is an improvement since the previous audit. Ten medication charts were sampled and prescribing met the legislative requirements. The GP or NP has reviewed the medication charts at least three monthly.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a cook and kitchen hand on duty each day. All baking and meals are prepared and cooked on site. There is a four week menu which was last reviewed May 2013 and due May 2015. Meals are transported to the dining room on trays in hot boxes.</p> <p>The cook receives a dietary notification for new residents and is notified of any changes including weight loss. Resident's likes and dislikes are known and alternative choices are offered. Food temperatures (cooked) are taken and recorded on each meal. All foods are dated labelled in fridges, freezers and chiller. There is daily fridge and freezer monitoring. Staff are observed wearing appropriate protective wear. Chemicals are stored safely when the kitchen is unattended. There is an opportunity for residents to feed back on the food service at resident meetings and through satisfaction surveys. All food services staff have attended food safety and chemical safety training. Residents and families interviewed spoke positively about the meals provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>PA Moderate</p>	<p>Pain assessments have been completed on admission and reviewed at least six monthly or earlier where the resident has identified pain. However there continues to be an improvement around pain assessments. Five files reviewed included a range of assessment tools. These have been reviewed at least six monthly.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	<p>FA</p>	<p>Short term care plans are available for use to document short term needs. Short term care plans sighted for weight loss and fall with injury reflect the resident's needs and reflected interventions to support care. Three of five care plans reviewed overall included interventions to support needs (link 1.3.6.1).</p>

delivery.		
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>PA Moderate</p>	<p>When a resident's condition alters, the registered nurses initiate a review and if required a GP consultation or referral to the appropriate health professional. Residents (two hospital and two rest home) and relatives (two hospital and two younger person with disability) interviewed state the residents needs are being met. There was evidence of neurological observations completed following falls with head injury.</p> <p>Adequate dressing supplies and continence products were sighted. Wound assessments and evaluations were sighted for five pressure areas of the sacrum (four grade 1 and one grade 2), one necrotic wound and three skin tears. There is evidence of wound nurse, GP and NP involvement in the wound management of pressure areas. There is an improvement required around short term care plans for wounds.</p> <p>Specialist continence advice is available as needed and this could be described by the clinical manager and RN.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities coordinator has been in the role four years and is currently completing the diversional therapy (DT) qualifications. She attends Radius DT meetings and conferences. The service received an award in 2014 for community connections focused on building community links. The programme is planned a month in advance, is varied and interesting and aimed to meet individual needs with one on one time, group activities and community connections and events. Entertainment and outings are offered. There is a team of volunteers involved including adult students. One of the 2015 goals for the activity coordinator is to form "Friends of Waipuna" group. Cultural needs are met with elders of different ethnicities visiting the home such as Kaumatua for Maori and Chinese Tai Chi instructors.</p> <p>There is comprehensive recreational, social and family information gathered for each of the younger disabled persons with an individualised plan developed in consultation with families. Families are involved (as confirmed on interview) in the six monthly review.</p> <p>Resident files evidenced activity plans are reviewed at the same time as the care plans with resident/family/whanau involvement.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	<p>FA</p>	<p>All initial care plans were reviewed by an RN within three weeks of admission and long term care plans developed. The long term care plans were evaluated at least six monthly or if there is a change in health status. There is a three monthly review by the GP. Care plan evaluations reviewed were up to date and accurately reflected the resident's needs. There are annual multidisciplinary team reviews that involve the resident/family/whanau. Relatives interviewed confirm they are invited to participate in care plan reviews.</p>

manner.		Care plans are evaluated six monthly or more frequently when clinically indicated.
<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 building holds a current warrant of fitness which expires on 23 December 2015.</p> <p>There have been a number of internal upgrades since the previous audit including redecorating and refurbishment of bedrooms as they become vacant. Double doors in bedrooms were being fitted on the day of audit. Bathrooms are being upgraded at one per month. The replacement of carpet is included in the Capex plan. There is an on-going planned maintenance programme in place. The proposal for a 29 bed extension is included in the business plan. The previous finding around the upgrade of facilities has been addressed and is on-going.</p> <p>External areas and pathways in the facility are well maintained. The previous finding around uneven areas of pathway has been addressed. A gardener maintains the gardens. There is no evidence of deadly nightshade in the garden or grounds. This is an improvement 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 programme.</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator (clinical manager) collates information obtained through surveillance to determine infection control activities and education needs in the facility. Definitions of infections are appropriate to the complexity of service provided. Trends are identified and quality initiatives put in place. Infection control data is collated monthly and reported at the quality/staff meetings. HCAs interviewed confirm infection control and surveillance data is discussed at staff meetings and information is displayed in the staff room as observed). Systems are in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. There were three residents with enablers (bedrails) in use. Enabler consent has been voluntarily signed by the resident. Enablers were linked to the care plans. The clinical manager is the restraint coordinator. Annual training in restraint is provided. The restraint approval committee meet monthly and review the use of restraints. There are three residents with restraints (two bedrails and three lap belts) Risks have been identified with the use of restraint and restraint monitoring in place. HCAs interviewed confirmed restraint/enablers are discussed at the clinical meetings.</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>	PA Low	Overall medication documentation identifies that medication is managed appropriately in line with required guidelines and legislation	Two glucagon kits were found to be expired and replaced on the day of audit	<p>Ensure there is a process in place around monitoring stock medication</p> <p>30 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified</p>	PA Moderate	Pain assessments have been completed on admission and reviewed at least six monthly or earlier where the resident has identified pain.	There has been no pain assessment for a new pain post fall (one hospital resident with injury post fall).	Ensure pain assessments are

via the assessment process and are documented to serve as the basis for service delivery planning.		However there continues to be an improvement around pain assessments.		completed as required  60 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Moderate	Families interviewed state they are informed promptly of any changes in the health status of their relative. The NP or GP examines and assesses residents of concern. Clinical staff interviewed confirm they are informed of resident changes to health through handovers, progress notes and short term care plans. Shortfalls were identified around interventions and STCPs.	(i) Interventions have not been documented to reflect the resident needs and supports for two hospital residents with identified weight loss (link hospital tracer); (ii) there were no short term care plans/or the LTCP updated for two residents with sacral pressure areas and one resident with necrotic toes.	Ensure interventions are documented to reflect the resident's needs and supports.  60 days

## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.