

TerraNova Homes & Care Limited - Brittany Residential Care

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

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

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

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

The specifics of this audit included:

Legal entity:	TerraNova Homes & Care Limited
Premises audited:	Brittany House Residential Care
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 September 2015 End date: 10 September 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:	44

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Brittany House Residential Care provides rest home level and hospital level care for up to 62 residents. The facility is operated by TerraNova Homes and Care Limited. Residents and families spoke positively about the care provided.

This unannounced surveillance audit has been undertaken to establish compliance with specified parts of the Health and Disability Services Standards and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff and a nurse practitioner. The one improvement required from the last audit has been addressed.

There are five areas requiring improvement resulting from this audit relating to resident documentation and the management of medicines.

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 demonstrated an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work and caring for residents. Information regarding residents' rights, access to interpreter services and how to lodge a complaint was available to residents and their family. Staff communicated with residents and family members following any incidents/accidents as appropriate. There have been no external investigations since the previous audit.

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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TerraNova Homes and Care Limited is the governing body and is responsible for the service provided at this facility. A business plan and quality and risk management systems are fully implemented at Brittany House Residential Care and documented scope, direction, goals, values, and a mission statement were reviewed. Systems are in place for monitoring the service provided, including regular reporting by the facility manager to TerraNova head office.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a clinical coordinator/registered nurse. The clinical coordinator is responsible for oversight of the clinical service in the facility.

There was evidence that quality improvement data is collected, collated analysed to identify trends and corrective action plans developed to address areas identified as requiring improvement. Graphs of various clinical indicators are available for staff to view along with meeting minutes. Risks have been identified and the hazard register is up to date. Adverse events are documented on accident/incident forms.

There are policies and procedures on human resources management and human resource processes are followed. There are current annual practising certificates for health professionals who require them. An in-service education programme is provided for

staff and attendance sheets are held on file. Staff are also encouraged to complete the New Zealand Qualifications Authority Unit Standards. Review of staff records evidenced individual education records are maintained.

There is a documented rationale for determining staffing levels and the skill mix in order to provide safe service delivery that is based on best practice. The facility manager and clinical coordinator are rostered on call after hours. Care staff reported there are adequate staff available and that they are able to get through their work. Residents and families reported there are enough staff on duty to provide adequate care.

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 on duty 24 hours a day at Brittany House Residential Care and provide support and guidance to care giving staff. All clinical staff have a verbal handover at the start of their shift and written handover sheets are also available. Detailed resident-related information is recorded on TerraNova's electronic documentation system. All permanent residents are on the interRAI assessment system.

The activities programme is a strength of the service. An experienced and enthusiastic activities coordinator leads a diverse activities programme for residents. The programme is based on the initial and ongoing evaluation of resident activity needs.

Residents are medically admitted in a timely manner, regularly reviewed by their doctor, and referred promptly if their clinical needs change. Individualised care plans are in place to guide care delivery, although there are improvements required related to the

timeliness of care planning and evaluation, the development of short-term care plans, and pain assessment practices. There are also a number of improvements needed in relation to medication management, including medicine reconciliation, medication fridge temperature monitoring, checking of the controlled drug register, expired medications, medication allergy status, the documentation of medication reviews, the administration of prescribed medications and the management of residents who are self-medicating.

Food services are well managed, comply with legislation and guidelines. Residents reported their enjoyment of meals. The kitchen is able to accommodate a variety of dietary needs and individual preferences. There are two large dining areas available for residents.

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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A current building warrant of fitness is displayed. Residents and families described the environment as meeting their or their relative's needs. The shortfall from the previous audit relating to cleaning equipment has been addressed.

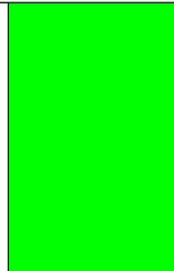
Restraint minimisation and safe practice

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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Documentation of policies and procedures and staff training demonstrated that residents are experiencing services that are the least restrictive. There were residents using restraint on the day of the 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.

Well-developed processes and systems are in place for collecting, analysing and responding to infection surveillance data. Systems also ensure that staff are kept informed about the surveillance results. Surveillance data is benchmarked internally with other TerraNova facilities, and also benchmarked with an external benchmarking organisation.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	13	0	1	3	0	0
Criteria	0	35	0	1	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The facility manager is responsible for the management of complaints. There are appropriate systems in place to manage the complaints processes. The complaints register reviewed evidenced there have been five complaints received for 2015.</p> <p>There have been no investigations by the Ministry of Health, District Health Board, Health and Disability Commissioner, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.</p> <p>Complaints policies and procedures are compliant with Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Systems are in place that ensured residents and their families are advised on entry to the facility of the complaint processes. Residents and families demonstrated an understanding and awareness of these processes. Resident meetings are held two monthly and residents are able to raise any issues during these meetings. Residents and families interviewed and review of resident meeting minutes confirmed this. Review of the collated resident survey for February 2015 evidenced residents understand the complaint process and were comfortable making a complaint.</p> <p>The complaint process and forms were observed to be readily accessible and displayed. Quality, staff, infection control, restraint, health and safety and registered nurse meeting minutes evidenced reporting of any complaints is an agenda item. Care staff confirmed information was reported to them via their meetings.</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>The service has an open disclosure policy which guides staff around the principles and practice of open disclosure. Education on open disclosure is provided at orientation and as part of the education programme. Staff confirmed their understanding of open disclosure. Communication with family was documented in the residents' progress notes. Incident/accident forms evidenced families were informed when incidents/accidents occurred.</p> <p>Interpreter services are available to residents via staff, family and interpreter services if needed. The clinical coordinator advised they have not required interpreter services.</p> <p>Residents and families confirmed communication with staff is open and effective. Care staff were observed communicating effectively with residents during the audit. Residents' files evidenced residents were consulted and informed of any untoward event or change in care provision and this was included in the multidisciplinary reviews of care. Residents and family responded positively concerning effective communication from the resident survey completed in February 2015.</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>There are established systems in place which define the scope, direction and goals of the organisation, as well as the monitoring and reporting processes against these systems.</p> <p>The service philosophy is in an understandable form and is available to residents and their family / representative and other services involved in referring people to the service. The facility manager shares weekly reports via teleconference with other managers within the TerraNova group. The meetings are facilitated by the chief executive officer (CEO). Meeting minutes include areas of risk, quality improvements, staffing, and occupancy.</p> <p>The facility is managed by a facility manager (FM) who is a registered nurse (RN) and has been in this position for two years. The facility manager is supported by a clinical coordinator who is a registered nurse and was appointed to their current position a year ago. Prior to this appointment, the clinical coordinator was a RN working on the floor. The clinical coordinator is responsible for oversight of clinical care.</p> <p>Review of the clinical coordinator's personal file, the facility manager's education record and interview of the clinical coordinator evidenced education has been taken in relevant areas.</p> <p>Brittany House is certified to provide hospital level and rest home level care. On the day of this audit there were 15 hospital level care residents and 29 rest home level care residents.</p> <p>Families and residents are informed of the scope of services and any liability for payment for items that are not included in the scope of services. This is included in the service agreement and admission agreements.</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>A quality and risk management plan is used to guide the quality programme and includes goals and objectives.</p> <p>The resident satisfaction survey was completed in February 2015 and results indicated that residents were highly satisfied with the services provided.</p> <p>Completed audits for 2014 and 2015, clinical indicators and quality improvement data was recorded on various registers and forms both hard copy and electronically. Quality improvement data is being collected, collated, and comprehensively analysed to identify trends including benchmarking by an external agency. Corrective actions are developed, implemented and reviewed.</p> <p>The facility manager provides weekly reports to the CEO. Meetings are held weekly and minutes were reviewed. The clinical coordinator stated quality data is discussed at the various meetings. Reporting of various clinical indicators and quality and risk issues was sighted in meeting minutes. Care staff reported that copies of meeting minutes are available for them to review in the staff areas.</p> <p>A newsletter is produced from the TerraNova head office which keeps residents and families informed with what is happening within the TerraNova group.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflect current accepted good practice, and references legislative requirements. Policies and procedures are reviewed by management and are current. Staff confirmed that they are advised of updated policies and that the policies and procedures provide appropriate guidance for the service delivery.</p> <p>A health and safety manual is available. Risks are identified and there is a hazard register that identifies health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. Adverse events are documented on accident/incident forms.</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</p>	<p>FA</p>	<p>Staff are documenting adverse, unplanned or untoward events on an accident/incident form. Accident and incident forms are reviewed by the facility manager and clinical coordinator and signed off when completed. Corrective action plans to address areas requiring improvement were documented on accident/incident forms. Registered nurses undertake assessments of residents following an accident. Neurological observations and falls risk assessments are completed following accidents/incidents as appropriate.</p> <p>There is an open disclosure policy. There was documented evidence of communication with family and the GP on the accident/incident form and in residents' progress notes following an adverse event and if there is any change in the resident's condition. Residents and family confirmed this.</p> <p>Staff confirmed they are made aware of their responsibilities for completion of adverse events through job</p>

open manner.		<p>descriptions and policies and procedures. Staff also confirmed they are completing accident / incident forms for adverse events. Policy and procedures comply with essential notification reporting (e.g., health and safety, human resources, infection control).</p> <p>The facility manager via phone reported no essential notifications have had to be made to external agencies since the previous audit.</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>Written policies and procedures in relation to human resources management are available. The skills and knowledge required for each position is documented in job descriptions which outline accountability, responsibilities and authority. These were reviewed on staff files along with employment agreements, reference checks, police vetting and completed orientations. Annual practising certificates are current for all staff and contractors that require them to practice.</p> <p>The facility manager is responsible for the education programme and the programmes for 2014 and 2015 were reviewed. Education sessions are provided at least monthly. Individual staff attendance records for each education session evidenced ongoing education is provided. Competency assessment questionnaires are current for medication management and restraint management.</p> <p>Care staff have either completed or commenced the New Zealand Qualifications Authority approved aged care education modules. Staff are also supported to complete education via external education providers.</p> <p>An appraisal schedule is in place and current staff appraisals were sighted on staff files held electronically.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff confirmed they have completed an orientation, including competency assessments (as appropriate).</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 documented rationale in place for determining service provider levels and skill mix in order to provide safe service delivery. Registered nurse cover is provided 24 hours a day, seven days a week. On call after hours are provided by the facility manager and clinical coordinator. The minimum number of staff on duty is during the night and consists of one RN and two caregivers.</p> <p>Care staff interviewed reported there is adequate staff available and that they are able to get through their work. All registered nurses and other staff including those who drive the facility's mobility van have a current first aid certificate. Residents and families reported staff provide them with adequate care.</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>All staff administering medication in the facility (registered nurses, enrolled nurses and senior caregivers) have been assessed as competent in medication administration. An observation of a medication round confirmed that medications were administered safely and appropriately. The pharmacy supplies medications to the service using the robotic system. Medication standing orders are not used by the service.</p> <p>A number of aspects of medication management were not consistent with legislative requirements and/or best practice (that is, medicine reconciliation, the monitoring of the medication fridge temperature, weekly checks of the controlled drugs register, expired medications not returned to the pharmacy, the documentation of three-monthly medication reviews, the recording of resident allergy status on the medication record, and the administration of medication as prescribed). Systems and processes are not in place to ensure the safety of residents who are self-medicating.</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>Experienced and well-qualified staff are responsible for food services within the facility. Resident satisfaction with food is monitored through the annual resident survey, and through informal feedback from residents, families and staff. The chef also advised that she undertakes regular 'taste tests' with residents in the Hub.</p> <p>On inspection, the kitchen was well maintained, clean and tidy. The procurement of food and food storage complied with all current legislation. Food in the fridge and freezers was dated and covered. Records were sighted of the recording of food temperatures prior to meals being served to residents. Cleaning schedules were sighted. The fridge and freezer temperatures are monitored daily, and records of this monitoring confirmed temperatures remained within recommended ranges.</p> <p>The kitchen caters for a range of nutritional requirements, including diabetic, vegetarian, soft and puree diets. Specialised crockery and cutlery, such as lip plates and feeding cups, are available to promote resident independence. A dietary profile is completed when residents are admitted and details of their likes/dislikes and special nutritional needs recorded on the kitchen whiteboard. The service runs a four weekly menu, including summer and winter options, as supplied by TerraNova. The chef described how individual dietary preferences are accommodated. Two large dining rooms are available for residents or they may have meals in their own room if they wish.</p> <p>Residents reported that they enjoyed their meals, and that alternatives were available to them if they didn't like what was on the menu.</p>
<p>Standard 1.3.6: Service</p>	<p>PA</p>	<p>Registered nurses are on duty 24 hours a day who provide support and guidance for care delivery staff. A</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>Moderate</p>	<p>doctor, who visits the service at least weekly, expressed satisfaction with the standard of care provided to residents, and of being advised in a timely manner if residents' needs changed. Residents and family members interviewed also stated they were happy with the care being delivered by the service.</p> <p>The clinical coordinator advised that all interRAI assessments, which incorporate a range of clinical assessments such as falls risk and pressure area risk, were current. There is no formal assessment of residents' pain levels and/or the effectiveness of their pain medication.</p> <p>Refer also to criterion 1.3.12.1 and to Tracer 2, criterion 1.3.3.1.</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>An enthusiastic, full-time activities coordinator, with more than 12 years' experience in this role, leads the diversional therapy service. She is supported by a diversional therapy assistant for an additional 12.5 hours weekly. A large central activities area, known as the Hub, is available for a range of group activities, such as entertainment, movies and discussion groups.</p> <p>Shortly after admission residents' previous and current interests are assessed, an individual activity plan is completed within three weeks and reviewed six monthly, as confirmed in resident records. These plans help inform the development of the activity programme.</p> <p>A written activity programme is provided to residents each weekly, and also promoted on several whiteboards around the facility. Activities available to residents during the week of the audit included bingo, board games, a range of clubs (such as mosaic club, singalong club, art club), twice-weekly outings, a daily discussion group, movies, entertainers, a pamper trolley and exercises. The activities coordinator meets with residents at the start of each year to confirm the activities programme is meeting their needs, and residents are also consulted about the activities programme at their bi-monthly meetings.</p> <p>Residents spoke very highly of their enjoyment of the activities programme, with several residents proudly displaying work they had completed as part of the art club.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>PA Moderate</p>	<p>Resident's regular nursing care plans were generally evaluated in a timely manner, although two resident care plans reviewed were not evaluated within the required timeframes. Refer to criterion 1.3.3.3. Evaluations are now being completed electronically, with hard-copy evaluation summary sheets sighted in a number of resident files. These evaluations were resident-centred and indicated progress towards achieving identified goals. The evaluation of resident wounds was well-documented. Nursing care plans and/or short term care plans were not developed in response to changes in residents' conditions.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	A current building warrant of fitness was displayed at the entrance to the facility that expires 1 January 2016.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	The effectiveness of the cleaning and laundry services is audited via the internal audit programme and completed audits were reviewed. The cleaner was interviewed and described the cleaning processes. Observation evidenced different coloured cloths and mop heads for cleaning bathrooms and bedroom floors are in use. The requirement from the previous audit has been addressed.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The surveillance of infection is well-managed by the service. Data is collected related to a range of infections, including wound, skin, urinary tract, upper and lower respiratory tract, gastrointestinal and eye infections. This data is entered onto the TerraNova electronic database system. Reports are generated monthly, data graphed, analysed for trends and any potential or actual issues identified and responded to.</p> <p>The infection control coordinator reported that surveillance information is reported to the facility manager monthly. Surveillance information is also reported at the monthly staff meetings, as sighted in meeting minutes, and staff can also access the infection control folder at any time. Surveillance data is also discussed with the organisation's clinical operations manager on a regular basis and benchmarked quarterly with an external benchmarking agency.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	Documented systems are in place to ensure the use of restraint is actively minimised. There were three residents using restraint and four residents using an enabler at the time of the audit. The clinical coordinator reported the restraint approval group forms part of the RN forum and all residents using restraint are reviewed. The TerraNova restraint minimisation steering group meets via teleconference three monthly. In-service education relating to restraint and challenging behaviour has been provided to all staff. Restraint usage is an agenda item for the quality/staff meetings. Care staff demonstrated good knowledge of restraint and enabler processes. Residents' files evidenced completed documentation relating to restraint and

		enabler use.
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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</p>	<p>PA</p> <p>Moderate</p>	<p>All staff administering medications have completed medication competency assessments, as sighted in staff files. During the audit visits, medications were stored securely, and the medication room was well organised. Medications are returned to the pharmacy when no longer required. An observation of a medication round confirmed that medication was being safely and appropriately administered. Medication administration records included details of staff administering the medications.</p> <p>All of the 16 medication charts reviewed contained a current photograph of the resident, medications were appropriately prescribed, discontinued medications initialled and dated, medication administration records were complete for all regular medication and the medication charts were legible. Three medication charts had no documentation related to the</p>	<p>Various aspects of medication management do not comply with statutory requirements and/or best practice guidelines.</p> <ol style="list-style-type: none"> 1. There was no documented evidence of medicine reconciliation when medications were received from the pharmacy. 2. There was gaps in the recording/monitoring of the medication fridge temperature over during August and for the beginning of September. 	<p>All aspects of the medication management system comply with legislative requirements and best practice.</p> <p>90 days</p>

<p>legislation, protocols, and guidelines.</p>		<p>resident's allergy status, and three charts had no evidence of a three-monthly medication review by their doctor.</p> <p>A registered nurse explained that all medication is checked by a registered nurse when it arrives from the pharmacy, but no evidence was sighted to confirm checking had taken place.</p> <p>The documentation recording the weekly temperature checking of the medication fridge was incomplete, with several entries missing for the month of August, and no entry for the current month.</p> <p>The date of first use of eye drops was recorded on those products currently in use. All medication on the medication trolleys and in the stock cupboards were within current use-by dates, but two medications kept under refrigeration had expired.</p> <p>Although evidence was sighted of six-monthly checks of the controlled drug register by the pharmacist, the required weekly checks of the register by facility staff were not consistently recorded over the last two months, with several entries missing.</p> <p>One resident was prescribed pro ra nata (as required) insulin to be given when blood sugar levels exceeded a specified level. The documentation of the resident's regular blood sugar monitoring indicated that this additional insulin would have been required on three separate occasions since February this year. There was no evidence available to confirm this medication had been given, although the administration records for all regular medications were complete.</p>	<p>3. The record of weekly checking of the controlled drug register over the past two months was incomplete.</p> <p>4. Two medications past their expiry date had not been returned to the pharmacy.</p> <p>5. Medication allergy status was not recorded on three resident medication charts.</p> <p>6. In three medication charts, records of three-monthly medication reviews by the doctor were incomplete.</p> <p>7. There was no evidence of pro ra nata (as required) medication being administered to one resident in accordance with their medication prescription.</p>	
<p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where</p>	<p>PA Moderate</p>	<p>Two residents are currently self-medicating. One resident self-medicates inhalers only with all their other medication administered by staff. The resident has not been assessed as competent in relation to self-medicating inhalers and there are no documented systems in place to ensure the medication is taken as prescribed.</p> <p>A second resident self-medicates all their medication. An initial</p>	<p>The management of resident self-medication is not consistent with best practice. One resident had not been assessed as competent in relation to the self-medication of inhalers. A second resident, who self-medicated all medications,</p>	<p>Systems are in place to ensure that residents safely self-medicate.</p>

appropriate.		competency assessment was completed in relation to the resident's ability to safely-self medicate. The resident's care plan documents the frequency of ongoing resident assessments of self-medication safety, but no further assessments have been completed as outlined in their care plan. The resident has a secure place to store their medication. The clinical coordinator advised that staff check on an informal basis each week that the resident is taking their medications appropriately but this is not documented. The resident's medication chart does not indicate which medications the resident's doctor has authorised for self-medication.	had not had their competency to self-medicate reassessed within required timeframes, and there was no evidence of formal monitoring that medications were being taken as prescribed.	90 days
Criterion 1.3.3.3 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.	PA Low	In all of the eight resident files reviewed, the medical admission of residents, and subsequent regular medical reviews had all been completed within the required timeframes. The required initial nursing assessment/care plan had been completed within the required time frames in all eight of the resident files reviewed. However, in two of those eight files, the full nursing plan had not been developed as required within three weeks of the admission date, and with a further two of those files the timeframes for completing evaluations of resident progress towards achieving care goals had not been achieved. The clinical coordinator confirmed she was aware there had been some delays with nursing staff meeting the timeframes for care plan development and evaluations.	Nursing care plans are not developed within three weeks of a resident being admitted to the service and/or evaluated at six monthly intervals.	All care plans are developed and evaluated within the required timeframes. 180 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and	PA Moderate	The clinical coordinator advised that all residents have now been assessed using the interRAI assessment system. The information generated from those assessments is used to help plan the provision of services and meet residents' identified needs, and is incorporated into the comprehensive electronic resident record and care planning system. On interview the doctor who visits the facility most regularly stated they had no concerns about the standard of care provided to residents. The assessment, treatment and ongoing evaluation records	There was no evidence of systematic, formal assessment of residents diagnosed with acute and/or chronic pain.	Appropriate clinical assessment tools are used to monitor residents' response to clinical

desired outcomes.		<p>related to wound management was well documented and reflected best practice., and felt the standard had increased The doctor on interviewed expressed satisfaction with the standards of care provided</p> <p>The management of pain was not as systematic. Formal pain assessments are not used to review the effectiveness of pain management for residents experiencing pain and the clinical coordinator advised these were not routinely used. No evidence was sighted that two residents receiving regular medication for pain (including controlled medication) had been assessed as to the effectiveness of that medication and whether additional interventions were required.</p>		<p>treatments.</p> <p>90 days</p>
<p>Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.</p>	<p>PA Moderate</p>	<p>The clinical coordinator explained that when resident progress was different from that expected, care plans were usually updated to reflect those changes, and the service does not routinely use separate short-term care plans. A review of four wound care records revealed that these plans were regularly updated to reflect changes to wound status.</p> <p>In two of eight resident progress notes reviewed, residents had experienced short-term clinical conditions which were not incorporated into the existing care plan, or a short-term care plan initiated. Refer also to Tracer 2, criterion 1.3.3.1.</p>	<p>Short term care plans are not consistently developed when a resident's care needs change and/or the service delivery plan updated.</p>	<p>Service delivery plans are updated, or short term care plans developed, when resident's care needs change.</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.