# Age Care Central Limited - Marire

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Age Care Central Limited

**Premises audited:** Marire Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 22 September 2015 End date: 22 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:** 37

# 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** |
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|  | 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 |
|  | 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

Marire Rest Home is owned and operated by Aged Care Central Limited, who operate Maryann Home and Hospital, which is also located in Stratford. Marire provides rest home level care for up to 38 residents. On the day of audit there were 37 beds occupied. The facility is now managed by a clinical manager with support from management who are based at Maryann Home and Hospital. Residents and relatives interviewed during the audit spoke positively about the care and support provided by staff.

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

There has been a change in management since the previous audit. A dedicated clinical manager has recently been appointed to manage the rest home. Prior to this, the nurse manager from Maryann Hospital and Dementia Unit oversaw the rest home. The clinical manager is a registered nurse with a current practising certificate. She is employed full-time and has a background in community nursing and health management. A part-time registered nurse who works three days a week supports her.

The service has addressed one of three shortfalls from the previous certification audit, which relates to building maintenance. Further improvements to medicines management and care plan documentation are required.

This audit identified that improvements are required to the process of conducting InterRAI assessments following admission and medication competencies.

## Consumer rights

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| 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 practices open disclosure and the clinical manager operates an open door policy. Families are informed of changes in residents’ health status or incidents in a timely manner. The right of the consumer to make a complaint is understood, respected, and upheld. Complaints processes are implemented and complaints and concerns are managed and documented.

## Organisational management

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| 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. |

The board of Aged Care Central Limited provides governance. The directors, the Chief Executive Officer and the manager ensure that services are planned, coordinated and appropriate to the needs of the residents. An established, documented, and maintained quality and risk management system is in place that reflects continuous quality improvement principles. The same system is used for both facilities. The service has a range of policies and procedures that are aligned with current good practice and service delivery, which are regularly reviewed. Incidents and accidents are managed according to policy. Quality improvement data is collected, analysed, and evaluated and the results communicated to staff and residents. Corrective action plans are utilised to make quality improvements within the service. Actual and potential risks are identified, documented and where appropriate communicated to residents, their family/whānau of choice, visitors, and those staff commonly associated with providing the services.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |

The clinical manager and the registered nurse are responsible for care planning processes. Care planning demonstrates that residents’ and their family participate in the care planning process. The service facilitates access to other medical and non-medical services. Planned activities are appropriate to the residents' interests. Residents interviewed confirmed their satisfaction with the programme. The activities programme supports the interests, needs and strengths of residents. Staff responsible for medicine management have attended in-service education for medication management. Three residents are self-administering medicines. All food is cooked on site. Residents and relatives interviewed confirmed satisfaction with food services. Systems for food procurement, storage and preparation and delivery are effective.

## Safe and appropriate environment

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| 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. |

The facility has a current building warrant of fitness. There have been no significant changes to the building since the previous certification audit.

## Restraint minimisation and safe practice

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| 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. |

Restraint minimisation is practiced. The service has alternative systems available so that staff can use restraint as a last resort strategy. On the day of audit there were no residents using enablers or restraints.

## Infection prevention and control

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| Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme. |  | Standards applicable to this service fully attained. |

The infection prevention and control programme includes the surveillance programme, managed by the clinical manager. There are established systems in place, which are appropriate to the needs of residents and visitors to the premises. There have been no outbreaks of infection since the previous audit.

## Summary of attainment

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

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| **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 | 2 | 0 | 0 |
| **Criteria** | 0 | 34 | 0 | 1 | 4 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | A complaints policy and procedure comply with Right 10 of the Code. Consumer complaints information is provided to residents and relatives on admission and available throughout the facility. The clinical manager is responsible for ensuring all complaints are fully documented and thoroughly investigated. There is a complaints register, which is up-to-date and includes relevant information regarding the complaint. There have been no consumer complaints since the previous audit. Resident and family interview confirmed that they are aware of how to make a complaint.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Five rest home residents and two relatives reported that staff communicated effectively. Staff practice open disclosure (confirmed in interview with seven staff [one CEO, one clinical manager, one registered nurse, four caregivers] and in review of five clinical records and all 10 incidents that occurred in August 2015). Interpreter services are available if needed. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The facility is owned and governed by Age Care Central Ltd (ACL), which operates Marire rest home and another facility - Maryann hospital and dementia unit. The chief executive officer (CEO) and three directors form the Board, undertake the governance role. There is a business plan 2012 – 2015 that includes a mission statement, vision and goals around governance, financial management, clinical management, people management and asset management. The business plan includes key performance indicators and progress against goals. The board monitors the business plan. There is an organisation quality management plan in place for the period 2014 to 2015. The board monitors performance of the service through two monthly board meetings and the CEO confirms two weekly contacts with the chairperson. There has been a change in management structure since the previous audit and a clinical manager role has been established at the rest home. The clinical manager commenced in the role a month ago. Prior to this, the nurse manager from Maryann hospital and dementia unit oversaw the rest home. The clinical manager is a registered nurse with a current practising certificate. She is employed full time and has a background in community nursing and health management. A part-time registered nurse who works three days a week at the rest home supports her. Staff employed at Maryann hospital and dementia unit, which has 24 hour registered nursing cover and corporate support, provide additional support. The clinical manager is aware of the need to maintain at least eight hours annually of professional development activities related to managing a rest home.Marire Rest Home provides care for up to 38 residents at rest home level care with 37 residents on the day of audit and no respite residents.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | An established quality and risk management system is in place that covers both sites. Key components of the quality system link to service delivery. Staff understand the system. There are a range of policies and associated procedures and forms in place that are generic throughout the company. Quality documents are reviewed two yearly as outlined in policy. The human resources manager based at Maryanne hospital coordinates the document review process with input from management. There is a quality and risk management system in place. Quality improvement data is reported at the weekly management meetings and the CEO to the Board conveys relevant information. Data is reported at the caregiver’s forum, which occurs monthly. Data is displayed in the caregivers reading folder in the staff room for those who are unable to attend the meeting. The quality and risk management plan contains objectives for the clinical manager to achieve. The clinical manager reports progress to the CEO at their weekly meetings. Corrective actions are identified through a range of systems and they are recorded in spreadsheets. The majority of corrective actions are identified through the internal audit programme. There is a system of hazard management in place that includes building hazards and business risks.Resident meetings are held four times a year and minutes are maintained. A resident survey is conducted annually, and was last completed this month and has yet to be collated. The 2014 survey showed high satisfaction rates. The rest home enjoys high occupancy and is supported by the community.Discussions with the clinical manager, the RN, the rest home coordinator (a senior caregiver) and three caregivers, and a review of meeting minutes demonstrate the ongoing involvement of staff in quality and risk activities.  |
| Standard 1.2.4: Adverse Event Reporting 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.  | FA | Staff complete incident and accident forms and a registered nurse undertakes an initial assessment and completes the relevant part of the form, which is logged in the electronic database. Once the event is logged electronically, the hard copy is then filed in the respective resident’s clinical record where relevant. The clinical manager and the registered nurse investigate incidents and accidents. There is a known process for the reporting and investigation of incidents. There is a discussion of incidents/accidents in monthly risk management meetings. Staff and resident incident and accident forms are recorded separately.All incident and accident reports for August 2015 were reviewed. There were a total of 10 events, which all related to falls. Residents with three or more falls for the month are reassessed and monitored. Appropriate interventions were followed-up in the short-term or long-term care plans. The clinical manager is aware of the requirement to notify relevant authorities in relation to essential notifications. There have been no events requiring notification. |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | Staff turnover is very low with some staff having worked for the rest home for many years. The service maintains a record of current annual practising certificates. The six employment records reviewed included the records of the clinical manager, the registered nurse, the rest home coordinator, and three caregivers. Some staff are employed through individual employment agreements and others are covered by the collective agreement. All records reviewed contained recruitment documentation, signed job descriptions, and records of orientation, training, evidence of first aid training, and performance appraisals. All staff receive an orientation prior to commencing at Marire. The clinical manager plans and coordinates training both internal and external. A record is held of all training provided and attendees. A number of training sessions are compulsory and attendance is reimbursed. Caregivers are encouraged to complete a recognised training programme. Records of medication administration competencies were not able to be evidenced (link #1.3.12.3). The two registered nurses have not yet completed InterRAI training. InterRAI trained registered nurses are able to be accessed through Maryann hospital and dementia unit. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a staffing policy, which provides the documented rationale for staffing, and skill mix. The clinical manager works Monday to Friday and provides on call cover with 24-hour registered nurse support from Maryann Home and Hospital. There is another registered nurse on duty at least three days per week and two enrolled nurses whom each work nine days a fortnight. There is a minimum of two caregivers on duty overnight. Interviews with the staff, residents and family members identified that staffing is adequate to meet the needs of residents.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Tablets are packaged in four weekly blister packs.  Ten of 10 medication charts reviewed had photo identification.  The blister packed medicines are reconciled on arrival by the registered nurse and any pharmacy errors recorded, errors are isolated from supply and then rectified with the supplying pharmacy.  Medicines are stored securely.  The medication folder included a list of specimen signatures. When administering medicines, staff were observed to be checking the medication order (which was a previous finding).  RNs or care givers administer medicines and medication training has been provided.  Not all staff that are responsible for medication administration have completed annual competencies.  Residents’ allergies are identified on the medication records.  The registered nurse advised there were three residents self-medicating on the day of audit.  The procedure for self-administering of medication by residents does not conform to the medicines care guides for residential aged care.  Medication charts and signing sheets reviewed did not all align with medication guidelines. Not all eye drops have been dated when opened and checking of controlled medication has not occurred as required. The medication fridge is monitored daily.  Medication charts reviewed identified that the GP had seen and reviewed the resident at least three monthly.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Marire rest home employs two cooks and the majority of food is cooked on site. Both cooks have attained food safety standards 167 and have safe food handling certificates (sighted). There is a four weekly rotating winter and summer menu, which is reviewed by a dietitian. A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents’ dietary needs are communicated to the kitchen as reported by the cook. Special diets are noted on the kitchen notice board, which is able to be viewed only by kitchen staff and in the communication book. Special diets being catered for include diabetic diets. There is an annual food service survey. All food in the pantry is rotated and stored off the floor. Opened food in the fridges and freezer is dated. The lunchtime meal was observed being served and was attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required. Residents interviewed report satisfaction with food choices and state meals are well presented.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | The registered nurse and caregivers follow the care plan and report progress against the plan each shift. Four of five care plans reviewed document changes to reflect changes in resident’s health status. Staff have access to sufficient clinical supplies. Monitoring of weight occurs as evidenced in four of five resident files reviewed. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and the process was known to staff. Wound assessments, monitoring and wound management plans were in place for seven residents. The wounds included one skin tear, four chronic ulcers, two skin cancers and one bunion. Interviews and documentation reviewed identified that wounds were appropriately managed. The previous audit finding related to wound care management plans has been addressed. The residents have individual GPs who visit at least three monthly and as required.  |
| Standard 1.3.7: Planned ActivitiesWhere 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. | FA | The qualified diversional therapist (DT) who works part time at Marire and part time at the services other facility develops individual and group activities programmes. A part time activity assistant assists the DT in the implementation of the programmes at Marire. The programmes are run over six days with resources available outside of activity hours for residents to use as they wish.On the day of audit, residents were observed being actively involved with a variety of activities. The group programme is developed weekly and all residents are given a copy, which details all activities occurring in the facility. Residents have an activities/social profile assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career, and family. Activities are age appropriate. The programmes include but are not limited to, one on one time for the individual programmes and current affairs, quizzes and exercises are included in the group programme. There are also visits from community groups, external speakers and entertainers. There are four church services a week including one on a Sunday. Residents provide regular feedback around their likes and dislikes of the activity programme to the activity staff through three monthly resident meetings or following activities. There are regular outings in the facilities own van. Resident files reviewed identified that their individual activity plan is reviewed six monthly when their care is reviewed. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans were evaluated six monthly, by the registered nurse in the files sampled. Residents and family are involved where possible in the reviews. Evaluations are documented and include progress towards meeting goals. There was documented evidence of four of five care plans being updated as required, with the exception of the resident with weight loss (Link 1.3.6.1). One resident who had fallen three times in the month of August had been reassessed using the InterRAI format. There is at least a three monthly review by the resident’s GP. There were short-term care plans in place to focus on acute and short-term issues in the sample of files reviewed.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The building has a current warrant of fitness, which is due to expire on 1 May 2016. There have been no alterations to the building since the previous certification audit. The previous audit identified that the doors and doorways in all wings had areas where the paint (ie, varnished wood) was peeling or where there were deep grooves and scratches. Since that audit, all doors and doorways in the wings have been painted. The service has addressed this previous finding. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The type of surveillance undertaken is appropriate to the size and complexity of the service and is determined in the infection prevention and control programme. The clinical manager manages the programme. Surveillance data is collected and the results of surveillance are acted upon, evaluated, and reported to relevant staff in a timely manner. Classification of infection events is included in policy. All infections are entered onto an infection register. Outcomes and actions are discussed at the monthly risk management meetings, and caregiver’s forum. Each resident has an individual infection report. There have been no infectious outbreaks since the previous audit.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | Restraint minimisation is practiced. The clinical manager oversees the restraint process within the facility. There are policies around restraint, enablers and the management of challenging behaviours in place to guide staff. The service currently has no residents using enablers or restraints. The service would use alternative systems if needed so that restraint would only be considered as a last resort strategy.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1A 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. | PA Moderate | Medicines are stored securely.  The service uses four weekly blister packs. Medication charts have photo identification.  There is a signed agreement with the pharmacy in place.  Staff sign for the administration of medicines on the medication signing sheet.  The medication folder includes a list of specimen signatures.  Medicines are stored securely.  Two medication charts contained evidence of transcribing, which was a previous audit finding that has yet to be resolved.  One of three medication charts reviewed where residents were prescribed controlled drugs, evidenced that two staff were signing for the administration the controlled drugs. | i) There were four expired medications in the cupboard including glucagon. ii) Three bottles of eye drops had not been dated on opening. iii) There was no documented evidence of regular weekly stock check of controlled medication. iv) There was no documented evidence that two staff were administering and signing for controlled drugs in two of three medication files reviewed. v) Five medication charts had medications that had not been given as prescribed and the reason for this was not stated. vi) Two of 10 medication charts had evidence of transcribing. vii) Two of ten medication charts had evidence of medication being administered that had not been charted. | i) Ensure that all expired medication is removed from the facility. ii) Ensure that all bottles of eye drops are dated on opening. iii) Ensure that there is documented evidence of weekly controlled drug stock checking. iv) Ensure that there is documented evidence that two staff administer controlled medication. v) Ensure that all medication is given as prescribed. vi) Ensure that transcribing ceases. vii) Ensure that when administering drugs, staff check medicines against the medication chart prior to administration and ensure that the general practitioner charts all medicines administered.30 days |
| Criterion 1.3.12.3Service providers responsible for medicine management are competent to perform the function for each stage they manage. | PA Moderate | Staff who administer medication have had recent medication administration education. There was no documented evidence of annual medication competencies being completed by a registered nurse who had been assessed as competent to administer medicines. On interview, the RN confirmed that competency assessments did occur. | There was no documented evidence of annual medication competencies being completed. | Ensure that all staff who administer medications have medication competency completed yearly.30 days |
| Criterion 1.3.12.5The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Moderate | Residents who self-medicate keep their medication locked in a drawer in their room. The resident records when they have taken the medication in a notebook. | The procedure for self-administering of medication by residents does not conform to the medication guidelines, for example, competency of the resident to self-administer was not being reviewed six monthly, staff were not checking each shift whether the medication had been taken or not by the resident and which medications were being self-administered was not documented on the medication chart. | Ensure that your procedure for residents who wish to self-medicate conforms to the medication guidelines.30 days |
| Criterion 1.3.3.3Each 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 | All residents are assessed on admission. Initial and long-term care plans are then completed following assessment and are reviewed in a timely manner. All InterRAI information was requested by the provider following admission. The provider had completed all their usual assessments following admission except for the InterRAI assessment of the resident admitted following 1 July 2015. | One resident admitted since 1 July 2015 did not have an InterRAI assessment completed within 21 days of admission.  | Ensure all residents admitted to the facility have an InterRAI assessment completed within 21 days of admission.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | Residents’ weight is recorded on admission and monitored monthly. Electronic scales are available for weight monitoring. One care plan did not document evidence of how the service had managed the resident's weight loss.  | There are no documented interventions in place for one resident with identified weight loss. | Ensure there are documented interventions in place for residents with weight loss.60 days |

# 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, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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End of the report.