

Amberley Resthome 2013 Limited

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:	Amberley Resthome 2013 Limited
Premises audited:	Amberley Resthome and Retirement Village
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 December 2015 End date: 10 December 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:	21

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Amberley Rest home and Retirement Village is privately owned and operated (for the last three years). The service is certified to provide rest home level of care for up to 33 residents including 12 studios (LTOs). On the day of the audit, there were 12 residents in the studios and nine residents (including one respite) in the rest home.

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. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, general practitioner, management and staff.

One of the owner/managers has previous experience in rest home administration and is on-site full time. She is supported by a part-time clinical manager/registered nurse who has been with the service two years. Long-serving and stable care staff support both managers.

Residents and relatives commented positively on the standard of care and services provided.

The service has addressed four of five findings from their previous certification audit regarding admission agreements, training, activity plans and repair to one bathroom.

There continues to be an improvement required around documented interventions.

This surveillance audit identified improvements required around internal audits, meetings, essential notifications, infection-control coordinator education, initial assessments and aspects of medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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There is evidence that residents and family are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated and appropriate to the needs of the residents. A facility owner/manager (non-clinical) and clinical manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management system is being implemented which includes collation of quality data including internal auditing, incident/accidents, surveys, and infection control rates and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. A comprehensive orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments.

Residents and families report that staffing levels are adequate to meet the needs of the residents.

Continuum of service delivery

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.
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Assessments, care plans and evaluations are the responsibility of the clinical manager/registered nurse. InterRAI assessments are in use for all residents. Care plans demonstrate allied health involvement in the care of the resident. Residents and relatives confirmed they were involved in the care planning and review process. The general practitioner reviews residents at least three monthly or more frequently if needed.

An activity coordinator provides an activity programme that meets the resident's individual recreational preferences. Residents are encouraged to maintain community links.

There are medication policies and procedures that meet legislation and guidelines. All caregivers who administer medications have completed an annual medication competency and medication education. The general practitioner reviews medication charts at least three monthly.

All meals and baking is done on site. The menu is varied, appropriate and reviewed by the dietitian. Individual dietary needs are catered for. Alternative options are provided.

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.

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 guide staff around consent processes and the use of enablers. The restraint coordinator (clinical manager/registered nurse) has a job description. Staff receive training in restraint and managing challenging behaviour. There were no residents with enablers or restraint use on the day of audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.
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The infection-control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	12	0	4	2	0	0
Criteria	0	34	0	6	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.10: 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>Residents and family are given information prior to, or on admission, regarding the services provided at the facility. Residents and family confirmed they have the opportunity to discuss the admission process and have been involved in decisions that affect the lives of the resident. Five admission agreements reviewed had been signed prior to or on the day of admission. The previous finding around signing of admission agreements 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>The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme. Complaints forms are available at both entrances to the facility. Information about complaints is provided on admission. Interviews with five residents and three family members confirmed that they understand the complaints process. They also confirmed that the managers and staff are approachable and readily available if they have a concern.</p> <p>Three (minor) complaints have been lodged in 2015 (year to date). The complaints register included all information and correspondence related to each complaint. Timeframes for responding to each</p>

		complaint were met and all three complaints have been resolved.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.</p> <p>Seven of seven incident/accident forms reviewed evidenced that families were notified following an adverse event. This may also be documented in the resident's progress notes. All three families interviewed confirmed they were notified of any changes in their family member's health status.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Amberley rest home is independently owned and operated.</p> <p>The service provides rest home level of care for up to 21 residents, which includes 12 serviced studios (LTOs). On the day of the audit, there were 21 rest home level residents including 12 in the studios and nine in the rest home (including one respite). All residents were on the Aged-Related Care Contract.</p> <p>The manager is one of the owners and is non-clinical. A clinical manager/registered nurse who works 20 hours per week and is on call, supports the manager. Afterhours RN support is also provided by the local GP service.</p> <p>The facility has a business plan, philosophy of care and goals and objectives. Specific aims for the year are documented and are regularly reviewed by the owner.</p> <p>The manager has completed a minimum of eight hours of professional development over the past 12 months relating to the management of an aged care facility.</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>	PA Low	<p>Quality and risk management systems are being implemented. Interviews with five staff (two caregivers, one clinical manager/registered nurse, a cook, and an activities coordinator) confirmed their understanding of the quality and risk management programmes.</p> <p>There are policies and procedures available to provide guidance to the service to meet accepted good practice and compliance to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The content of policy and procedures is detailed to allow effective implementation by staff. A document control system to manage policies and procedures is in place.</p> <p>The quality and risk management programmes include an internal audit programme and data collection,</p>

		<p>analyses and review of adverse events including accidents, incidents, infections, wounds, pressure injuries and challenging behaviours. The internal audit schedule was not always followed. A corrective action process was not always implemented where opportunities for improvements had been identified. The site meeting schedule was not consistently followed. There was no documented evidence of audit results and quality data being consistently communicated to care staff in staff meeting minutes.</p> <p>The health and safety programme includes policies to guide practice. Staff accidents and incidents and identified hazards are monitored.</p> <p>Falls prevention strategies were in place including the analyses of falls and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. Seven incident forms were reviewed and all were completed appropriately and in a comprehensive manner. The five residents' files reviewed demonstrated all documented accident/incident forms for the residents also had the events documented in the residents' progress notes.</p> <p>The facility manager was unaware of the essential notifications required to relevant authorities. A Section 31 notification was made on the day of audit for an incident that occurred on 19 November 2015.</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. Current practising certificates were sighted for all health professionals. All five staff files randomly selected for review had relevant documentation relating to employment. Annual performance appraisals were completed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.</p> <p>There is an education plan being implemented that covers all contractual education topics, and exceeds eight hours annually. All in-service topics that were scheduled on the education planner had been delivered. The previous audit finding related to education and training has been addressed. The clinical manager/registered nurse has completed InterRAI training.</p>
Standard 1.2.8: Service Provider	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>delivery. Sufficient staff are rostered to manage the care requirements of the residents. The clinical manager/registered nurse works 20 hours per week. Outside of these hours, she is on call. Back-up registered nurse support can be accessed via the local GP service. Additional staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are medication policies in place that meet the MOH medication management guidelines. Caregivers who administer medications have completed annual medication competencies with the exception of the clinical manager. The RN checks all medications on delivery. Any discrepancies are fed back to the supplying pharmacy. All medications sighted were within the expiry dates. There was a shortfall identified around the competency assessment for one self-medicating resident.</p> <p>Ten medication charts were reviewed and all had photographs however, the allergy status had not been identified on all charts. Prescribing of medications did not meet the legislative requirements. All 10 medication charts had been reviewed three monthly by the GP.</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>The service employs a head cook Monday to Friday and weekend cooks. All meals and baking are cooked on site. The cooks have completed food safety and hygiene units. There is a food services manual in place to guide staff. A dietitian has reviewed the summer menu February 2015. The clinical manager notifies the cook of residents dietary preferences including likes and dislikes. Residents interviewed spoke positively about the meals and stated their dietary needs are accommodated, including alternative options. Special diets provided are vegetarian meals and diabetic desserts.</p> <p>Temperatures of refrigerators, freezers and end-cooked foods are taken and recorded daily. Chilled goods temperatures are checked on delivery. All food was stored appropriately and dated. Chemicals are stored safely. A cleaning schedule is maintained.</p> <p>Residents have an opportunity to provide feedback and meal suggestions through the resident meetings and surveys.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and</p>	<p>PA Low</p>	<p>When a residents condition changes the RN initiates a GP visit or nurse specialist consultation. Short-term care plans are developed for the management of short-term needs and changes in a resident's health status. There is evidence of relative notification of health status changes as documented on the family/whānau contact sheet.</p> <p>Monitoring forms sighted were in use for behaviour, weight, food and fluids. The effectiveness of pain</p>

<p>desired outcomes.</p>		<p>relief had not been reported in the notes of one resident. The previous finding around interventions remains.</p> <p>Staff have access to sufficient medical and dressing supplies. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence and wound advice is available as needed and nurse initiated referrals could be described.</p> <p>Wound assessment, wound progress and dressing record forms are available for use. There was a short-term care plan in place for one minor wound under the care of the district nursing team.</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 service employs an activity coordinator for 15 hours a week Monday to Friday. The activity coordinator has a dual role as an administrator and the activity hours are flexible, dependent on the activity such as outings. The activity coordinator has a current first aid certificate. Care staff ensure planned activities for the weekends are implemented.</p> <p>The monthly programme includes a variety of activities that meets the recreational preferences and abilities of the residents such as exercises, bowls, discussions and quizzes, crafts and happy hours. Residents were observed participating in activities throughout the day. Community links are maintained with visits into the community, inter-home visits, drives and outings, regular entertainment, pet therapy and visiting schoolchildren. There are fortnightly church services. There are volunteers involved in the activity programme. One volunteer takes residents for Pilates.</p> <p>Three monthly resident meetings provide residents with an opportunity to provide feedback on the activity programme.</p> <p>A resident profile is completed on admission. Each resident has an individual activity plan, which is reviewed at the same time as the clinical care plans. The previous finding around activity plans has been addressed.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Care plans reviewed were updated following the six monthly evaluations and as changes occur in three of five resident files reviewed. One resident was on respite care and the other resident had not been at the service six months. There were written evaluations against the care plan goals that evidenced if the goals were met or unmet. There is multidisciplinary input into the review process. Relatives confirmed they are involved in the care plan review. The GP reviews the resident at least a three monthly. Short-term care plans (sighted) were used for short-term needs. Short-term care plans were evaluated and resolved, or added to the long-term care plan if the problem was ongoing.</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	The building holds a current warrant of fitness, which expires on 1 October 2016.
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	There are adequate numbers of communal toilets and shower rooms per wing. Residents interviewed state their privacy was respected when staff were attending to their personal hygiene needs. There are engaged/vacant signage on communal toilets and showers. Bedrooms have basins. The damaged flooring identified at the certification audit has been replaced. The previous finding 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>	PA Low	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly, to identify areas for improvement or corrective action requirements. Infection control internal audits have been completed. Infection rates have been low. Trends are identified, however quality initiatives are not always discussed at staff meetings (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>There have been no outbreaks since the previous audit. Systems in place are appropriate to the size and complexity of the facility. The clinical manager/registered nurse has not completed any infection control education in the past 12 months.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service is committed to restraint minimisation and safe practice, as evidenced in the restraint policy and interviews with clinical staff. There is a documented definition of restraint and enablers, which is congruent with the definition in NZS 8134.0. The policy identifies that restraint is used as a last resort. A restraint coordinator who is the clinical manager/RN oversees restraint minimisation.</p> <p>There were no residents using enablers or restraints on the day of audit.</p> <p>An external consultant has provided staff training on restraint and challenging behaviours.</p>

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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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	<p>Amberley has a site meeting schedule as part of the organisational quality and risk programme. Not all site meetings detailed on the schedule were held and not all meetings were held as frequently as described on the meeting schedule. Evidence of audit results and quality data being consistently communicated to staff via meeting minutes was missing.</p>	<p>The site meeting schedule documented as part of the quality and risk programme was not being followed. Information relating to audits, clinical indicators, accidents and incidents, and infection control was not consistently evidenced in meeting minutes.</p>	<p>i) Ensure that all scheduled meetings as described as part of the quality and risk programme are held at the scheduled times.</p> <p>ii) Ensure that information and analysis of data captured as part of the quality and risk programme is consistently communicated to staff and documented in</p>

				meeting minutes. 90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Where areas are identified for improvements following internal audits, corrective actions are documented on a corrective action form. Missing is evidence that corrective actions have been implemented and signed off by the manager.	There is a lack of evidence to verify that corrective action plans are implemented and signed off.	<p>Ensure there is evidence to verify corrective action plans are implemented and signed.</p> <p>90 days</p>
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	Police were involved regarding a suspected intruder in the grounds. The incident was appropriately documented and investigated but there was no notification made to the Ministry of Health regarding the police being called to the site.	The service provider failed to complete a Section 31 notification to the Ministry of Health following a request for police assistance to the site.	<p>Ensure that all essential notifications are made to the correct authority when required.</p> <p>90 days</p>
<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 Moderate	On four of the 10 medication charts reviewed, GP prescribing of medications met all legislative requirements. 'As required' medications recorded the date and time of administration. All of the administration signing sheets corresponded with the medication charts. Medication documentation shortfalls were identified.	(i) There was no indication for the use of 'as required' medications on four of 10 medication charts, (ii) Five medications prescribed on one medication chart did not evidence the date of prescribing or the signature of the prescriber. Another medication chart did not evidence a date or signature for the discontinuation of a medication, and (iii) Three of ten medication charts did not identify the resident's allergy status.	(i) and (ii) Ensure medication charts meet the legislative requirements for the prescribing and discontinuation of all medications and (iii) Ensure all medication charts identify the allergy status of the resident.

				30 days
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	Senior caregivers complete a written medication competency and practical observation of the administration of medications before being deemed medication competent. The care staff also complete insulin competencies. Medication competent staff attend annual medication education and complete annual competencies.	The clinical manager/RN has not completed an annual medication competency.	<p>Ensure the clinical manager/RN completes an annual medication assessment.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Moderate	There was one resident self-administering a medication subcutaneously under observation. The clinical manager/RN has completed an initial self-medication competency which has not been reviewed three monthly as per policy. The GP reviews the resident medications three monthly however has not signed the self-medication competency form. The signing sheet evidences the medication has been self-administered as prescribed.	The self-medication competency has not been signed by the GP and the competency has not been reviewed three monthly.	<p>Ensure self-medicating competencies are reviewed three monthly and signed by the GP.</p> <p>60 days</p>
<p>Criterion 1.3.3.1</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is undertaken by suitably qualified and/or experienced service providers who are</p>	PA Moderate	An initial assessment is completed for all residents including respite care residents within 24 hours of admission. Three of five initial assessments had been completed by the clinical manager/RN.	Two initial assessments (one rest home resident and one respite care resident), had not been completed by a qualified person to undertake clinical assessments.	<p>Ensure the registered nurse completes all initial assessments.</p> <p>60 days</p>

competent to perform the function.				
<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 Low	Residents and family members confirm care delivery and support is consistent with their expectations. Relatives state they are notified of any significant events/health status changes and are kept informed of progress. Three of four long-term resident files documented appropriate interventions to guide staff in safe delivery of care.	There was no documented evidence for the effectiveness of 'as required' analgesia for one resident with identified pain.	<p>Ensure the effectiveness of analgesia is documented.</p> <p>60 days</p>
<p>Criterion 3.5.1</p> <p>The organisation, through its infection control committee/infection control expert, determines the type of surveillance required and the frequency with which it is undertaken. This shall be appropriate to the size and complexity of the organisation.</p>	PA Low	The clinical manager is responsible for the infection control programme on site. The clinical manager delivers the training and undertakes the audits related to infection control. The clinical manager has not completed education related to infection control in the past 12 months.	The person responsible for infection control has not completed training related to infection control in the past 12 months.	<p>Ensure the infection control coordinator completes education related to infection control, annually.</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.