# Oceania Care Company Limited - Whareama Rest Home & Hospital

## 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 Central Region's Technical Advisory Services 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:** Oceania Care Company Limited

**Premises audited:**

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 11 February 2016 End date: 12 February 2016

**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:** 65

# 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

Whareama Rest Home and Hospital (Oceania Care Company Limited) can provide care for up to 79 residents requiring care at either rest home or hospital level. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

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

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and regional and executive management team. Service delivery is monitored.

An improvement is required to medication management.

## 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. |

Staff interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated. Documentation is completed and stored in the complaints folder. Staff communicate with residents and family members following any incident, with this recorded in the resident’s files. Residents and family state that the environment is conducive to communication including identification of any issues.

## 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. |

Whareama Rest Home and Hospital has documentation of the Oceania Care Company Limited quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented. Corrective action plans are documented with evidence at times of resolution of issues when these are identified.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and staffing. Rosters indicate that staff are replaced when on leave. The service has implemented an orientation and training programme for all staff.

## 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 low risk. |

Service provision is coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into care planning and access to a range of life experiences and choices. Sampling of residents' clinical files validated service delivery to the residents. Resident’s care planning is changed according to the needs of the resident when progress is different from expected. The service uses short term care plans for acute problems.

The residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Medication areas, including controlled drug storage, evidence a secure medicine dispensing system. Review of staff competencies confirmed all staff have current medication management competencies. Eight residents were self-administering some of their medicines. Self-administration of medicines occurs according to policy. There is a requirement for improvement relating to three monthly medicines reviews to be completed for all residents.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety training.

## 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. |

There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate, with indoor and outdoor areas that meet their needs.

## 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 policy and procedures are congruent with the restraint minimisation and safe practice standard. Documentation of restraints and enablers includes identification of risks and monitoring time frames. Definition of restraint and enabler use is congruent with legislation. There is a job description for the restraint coordinator and the service is maintaining a restraint register.

## 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 policies include guidelines on prevention and minimisation of infection and cross infection. Staff are familiar with infection control measures and the use of personal protective equipment.

The infection control surveillance programme is appropriate for the size and complexity of the services provided. Surveillance is completed at monthly intervals and contributes to the quality improvement within the facility.

## 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 | 15 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 1 | 0 | 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 | The organisation’s complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include periods for responding to a complaint. Complaint’s forms are available in the facility.  A complaints register is in place and the register includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaints folder. Two complaints were tracked and the review indicates that all timeframes taken to inform the family and resolve the issues raised were met.  Residents and family members all state that they would feel comfortable complaining.  There have not been any complaints forwarded by the Health and Disability Commission or to any other external authority. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorneyof any accidents/incidents that occur. These procedures guide staff on the process to ensure full and frank open disclosure is available.  If the resident has an incident, accident, a change in health or a change in needs, then family are informed as confirmed in a review of accident/incident forms and in the residents’ files.  Files reviewed include documentation around family contact. Interviews with family members confirm they are kept informed. Family confirm that they are invited, at least six monthly, to the care planning meetings for their family member.  Interpreting services are available, when required, from the district health board. The business and care manager states that families are involved in resident care and can interpret when required. There were no residents requiring interpreting services at the time of the audit.  All residents interviewed confirm that staff are approachable and communicate in a way that meets their needs. The business and care manager has an open door policy that allows residents, family and staff to communicate any issues at any time.  An information pack is available in large print and staff interviewed advised that this could be read to residents.  Staff training records include training around connecting with people and communication. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Whareama Rest Home and Hospital is part of the Oceania Care Company Limited, with the executive management team, including the chief executive officer and organisational management team providing support to the service, as required.  Oceania Care Company Limited has a clear mission, values and goals and staff interviewed are able to describe these. These are displayed in the service and residents and family interviewed are familiar with these.  The facility can provide care for up to 79 residents requiring rest home or hospital level of care with four rooms identified as dual-purpose. During the audit, there was occupancy of 65 residents (40 requiring rest home level care and 25 requiring hospital level care). All residents are over 65 years.  The business and care manager has been in a management role in Oceania Care Company Limited for seven years. The business and care manager is a registered nurse with a current annual practicing certificate, a diploma in management level five and is currently completing a master’s in business administration. The business and care manager has over eight hours training per year in relevant topics. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Whareama Rest Home and Hospital uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice. The business plan is documented and reporting occurs through the business status reports. This includes: financial monitoring; review of staff costs; progress against the healthy workplace action plan; review of complaints; incidents; relationships and market presence action plan and review of physical products. The service is monitoring staffing as a result of the trends able to be analysed.  The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews, as required, with all policies current. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff and new and revised policies are signed by staff to say that they have read and understand them. The policy around pressure injuries has been reviewed and is ratified. Staff state they have had the read the policy.  Service delivery is monitored through: complaints; review of incidents and accidents; surveillance of infections and implementation of an internal audit programme. Quality improvement data is analysed through meetings and benchmarking and corrective action plans are documented with evidence of resolution of issues.  There are monthly meetings with minutes documented that include the following: management; health and safety; staff; quality; registered nurse and resident and family meetings. All staff interviewed report that they are kept informed of quality improvements.  The service focuses on projects to improve the quality of care provided. Projects documented indicate: significant improvements in reduction of falls; improvements in administration of medication and improvements in skin tears. The service proactively responds to any national focus in clinical care and in any changes when analysing clinical data. The service is now focusing on preventing pressure injuries with a literature review completed and strategies introduced to improve service delivery.  The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which include a documented hazard management programme and a hazard register for each part of the service. Any hazards identified are signed off as addressed or risks are minimised or isolated.  There is a six monthly satisfaction survey for residents and family. The 2015 surveys indicates that residents and family are very satisfied with services provided. This was confirmed through interviews with family and residents on the days of audit. |
| 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 | The business and care manager and clinical manager are aware of situations in which the service would need to report and notify statutory authorities including: police attending the facility; unexpected deaths; critical incidents; pressure injuries as per guidelines and infectious disease outbreaks. Times when authorities have had to be notified are documented and retained on the relevant file. This includes notification of the appointment of the clinical manager to HealthCERT.  The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff records reviewed demonstrate that staff receive education at orientation on the incident and accident reporting process. Staff interviewed understand the adverse event reporting process and their obligation to documenting all untoward events.  Incident reports selected for review have a corresponding note in the progress notes to inform staff of the incident. There is evidence of open disclosure for each recorded event. Information gathered is regularly shared at monthly meetings with incidents graphed, trends analysed and benchmarking of data occurring with other Oceania Care Company Limited facilities. |
| 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 | Human resource policy and processes are in place. All registered nurses hold current annual practising certificates. Current visiting practitioners’ practising certificates reviewed are current and include: the general practitioners; pharmacists; dietitian; podiatrist and physiotherapist. Staff files include employment documentation such as: job descriptions; contracts; and appointment documentation on file. Criminal vetting is completed and an annual appraisal process is in place with all staff files reviewed having a current performance appraisal on file.  A comprehensive orientation programme is available for staff. Staff files show completion of orientation. Staff are able to articulate the buddy system in place and the competency sign off process completed. A new staff interviewed state that they have had an orientation that included reading of policies and procedures, introduction to residents, staff and to the service processes.  Training is identified on a training schedule. A training and competency file is held for all staff, with folders of attendance records and training with electronic documentation of all training held. Staff receive annual training that includes attendance at training sessions. Annual individualised training around core topics such as: medication; restraint; infection control; health and safety; manual handling and continence. Registered nurses have an hour of training at each meeting that includes: relevant topics such as pain management; complaints management; nutrition; assessments; medication administration and falls. All registered nurses have completed training around pressure injuries in 2015.  There are five registered nurses trained to complete interRAI assessments and another who is enrolled in training.  The training register and training attendance sheets show staff completion of annual medication and other competencies such as: hoist; oxygen use; hand washing; wound management; moving and handling; restraint; nebuliser; blood sugar and insulin. Education and training hours exceed eight hours a year for all staff reviewed. The health care assistants state that they value the training. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy. Rosters indicate that residents requiring either hospital or rest home level of care are supported by an adequate number of staff on duty at any given time.  There is a registered nurse (RN) on duty at all times both in the hospital and rest home areas with one RN on duty overnight. Hospital residents who are located in the rest home area are clustered together and the registered nurse and allocated staff provide extra care and support. Rest home residents in the hospital area are also clustered together and are close to the activities area and main reception to ensure they receive adequate social support and are able to be engaged appropriately.  Residents and families interviewed confirm that staffing is adequate to meet the residents’ needs during the weekdays. The same staffing model is applied at weekends.  There are 91 staff at the time of the audit, including the business and care manager and the clinical manager. The household staff are appointed and include cleaners who provide seven day a week support, a chef,kitchen staff and dedicated laundry staff. There are activities staff who provide an activities programme five days a week and health care assistants who provide support to 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 Low | Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly physical stocktakes. The medication fridge temperatures are conducted and recorded.  Current medication competencies for staff who administer medicines were sighted. The medication round was observed and evidenced the staff member was knowledgeable about the medicines administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures.  Medication audits have been conducted and corrective actions are implemented following the audits. There were eight residents self-administering medicines (mainly eye drops and nasal sprays) at the facility and this was conducted, according to policy. There is a requirement for improvement relating to the GP not completing three monthly medicines reviews for all the residents within the required timeframes. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | Interview with the chef confirmed kitchen staff have completed food safety training, and this was verified by food safety certificates. In interview, the chef confirmed they were aware of the residents’ individual dietary needs. The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided.  On inspection, the kitchen environment was clean, well lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures.  There is a seasonal menu, last reviewed by a dietitian in August 2015. Review of residents’ files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available.  There was enough stock to last in an emergency situation, for three days, for all residents. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The residents' person’s centred care plans (PCCP) evidence the required interventions, desired outcomes or goals of the residents. The GP documentation and records are current (refer to criterion 1.3.12.1). In interviews, residents and family confirm their and their relatives’ current care and treatments meet their needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. |
| Standard 1.3.7: Planned Activities  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. | FA | The service employs a diversional therapist (DT) who has an occupational therapy qualification and an activities coordinator responsible for residents’ activities. In interview with the DT, they confirmed the activities programme is available to all residents in the rest home and the hospital, sighted a copy of the programme. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.  There are activities assessments and activities care plans in residents’ files reviewed. Activities care plans in the residents’ files reviewed had intervention relating to the activities goals. The residents’ activities attendance records are maintained as are activities progress notes. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Time frames in relation to care planning evaluations are documented. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.  The residents’ progress records are entered on each shift. When resident’s progress is different than expected, the RN contacts the GP, as required. Short term care plans were sighted in some of the residents’ files, and these are used when required. The family are notified of any changes in resident's condition, confirmed at family interviews.  There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date December 2016). There have been no building modifications since the last audit.  A planned maintenance schedule is implemented and the maintenance staff and documentation confirmed implementation of this.  The lounge areas are designed so that space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids.  Equipment relevant to care needs is available and staff confirm that there is always sufficient equipment. A test and tag programme is in place. Equipment is calibrated on an annual basis.  There are safe external areas for residents and family to meet/use and these include paths, seating and shade. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance is aligned with the organisation’s policies. Infections are recorded as quality indicators on the intranet. Residents with infections have short term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on monthly at staff, quality, and infection control and health and safety meetings.  The clinical manager (CM), who previously worked as an infection control nurse specialist (ICNS) in another service, is overseeing the surveillance programme during the absence of the infection control coordinator (ICC), who was on annual leave. The ICC completed additional training for the role as the ICC.  The type of surveillance undertaken was appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events. Infection summary logs are maintained for infection events in individual resident’s files reviewed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. Restraint and enabler use are documented in residents’ care plans. There is a job description for the position of the restraint coordinator. The restraint register is maintained. The service had three restraints and one enabler in use at the time of the on-site audit. |

# 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)** |
| Criterion 1.3.12.1  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. | PA Low | Medicines management processes are documented in policy. The system promotes safe and appropriate dispensing, administration, review, storage, disposal and reconciliation. Three monthly reviews were not consistently completed. | Not all residents reviewed had the three monthly medicines review completed in a timely manner. | All residents to have their medicines reviewed by the GP, at three monthly intervals.  30 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.