

# Radius Residential Care Limited - Radius St Helena's Care Centre

---

## 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:

<b>Legal entity:</b>	Radius Residential Care Limited
<b>Premises audited:</b>	Radius St Helena's Care Centre
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 14 March 2016 End date: 15 March 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	41

# 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

Radius St Helena's is part of the Radius Residential Care Group. St Helena's cares for up to 52 residents requiring hospital and rest home level care. On the day of the audit there were 41 residents.

The facility manager has been in the role for three months and has experience in aged care management. She is supported by a relieving clinical manager and the Radius regional manager.

Residents and family interviewed spoke positively about the service provided.

One of the two shortfalls identified at the previous audit has been addressed. This was around infection control surveillance. Improvement continues to be required around care planning.

This audit has identified additional improvements required around complaint management, incident reporting of pressure injuries, interRAI assessments and timeliness of risk reassessments, medication management, self-administering residents and first aid training for staff.

## 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.		Some standards applicable to this service partially attained and of low risk.
--	--	---

There is evidence that residents and family are kept informed. The rights 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 medium or high risk and/or unattained and of low risk.
---	--	--

Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager is responsible for the day-to-day operations of the facility. Quality and risk management processes are maintained. Strategic plans and quality goals are documented and regularly reviewed. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan and robust health and safety processes. Human resources are managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff. Education is provided for staff. Registered nursing cover is provided twenty four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

## Continuum of service delivery

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

Initial assessments and risk assessment tools are completed by the registered nurses on admission. Registered nurses are responsible for care plan development with input from residents and family. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Medications are stored in line with legislation and current regulations. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

## Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
---	--	---

A current building warrant of fitness is posted in a visible location.

## 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.

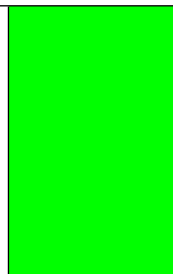


Standards applicable to this service fully attained.

The service has alternative systems available so that staff can use restraint as a last resort strategy. There were three residents voluntarily using bedrails as enablers on the day of the audit. Care plans include reference to the use of enablers. Two residents were using restraints.

## Infection prevention and control

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



Standards applicable to this service fully attained.

St Helena's has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	11	0	3	3	0	0
<b>Criteria</b>	0	33	0	4	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>PA Low</p>	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are accessible to residents and family. Information about complaints is provided on admission. Interviews with five residents (one hospital level and four rest home level) and family members confirmed their understanding of the complaints process. Care staff interviewed (three healthcare assistants, two registered nurses and one activities coordinator) were able to describe the process around reporting complaints.</p> <p>Verbal and written complaints received are recorded on a complaints register. There is evidence that these complaints have been managed in a timely manner including acknowledgement, investigation, meeting time lines, corrective actions when required and resolutions. One complaint received via the Health and Disability Commissioner in 2015 did not evidence contact with the complainant, investigation of issues or development of a corrective action plan following the complaint.</p> <p>Three complaints were reviewed from 2015 (there have been none in 2016). Two, including one via the DHB, were managed within the required timeframes as determined by the Health and Disability Commissioner. A corrective action plan was developed and implemented following the complaint involving the DHB. The one complaint received via the Health and Disability Commissioner in 2015 was referred to HealthCERT, with a request of review of the issues during this audit. The audit identified appropriate management of resident privacy, independence and respect, appropriate menu and food management services, appropriate maintenance management systems including repair of minor and more major issues and preventative maintenance and suitable toileting, shower/bathing and communal facilities. Complaints are linked to the quality</p>



		and risk management system.
<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>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/health issues arises. Two families (one from the hospital and one from the rest home) interviewed stated they were kept well informed. Ten incident/accident forms were reviewed and identified that the next of kin were contacted or if not, justification as to why. Residents' meetings are held two monthly.</p> <p>The service can access interpreter services through the District Health Board. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</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>Radius St Helena's is part of the Radius Residential Care Group. St Helena's cares for up to 52 residents requiring hospital and rest home level care. All rooms can be used for either hospital or rest home level care. On the day of the audit, there were twenty-five rest home level residents including two on young persons with disabilities contracts and sixteen hospital residents including two on long term chronic conditions contracts.</p> <p>The Radius St Helena's business plan April 2014 to March 2017 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>The facility manager began employment in the role in November 2015, having previously managed aged care services. She is supported by an acting clinical manager (while the clinical manager is on maternity leave) and the regional manager.</p> <p>The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	FA	<p>A robust quality and risk management system is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Policies and procedures have been updated to reflect the implemented interRAI procedures.</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The monthly collating of quality and risk data includes monitoring clinical effectiveness, work effectiveness, risk management/falls and consumer participation. Data is collated and benchmarked against other Radius facilities. A resident satisfaction survey is conducted each year. Results for 2015 reflected high levels of resident satisfaction with the services received. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified (with exception refer #1.1.13.1). There is evidence of corrective actions being communicated to all staff and regularly evaluated. They are signed off by management when completed.</p> <p>Falls reduction strategies include staff knowing the residents who are at risk, managing challenging behaviours effectively, adhering to residents' routines and anticipating their needs and intentional rounding with frequencies determined by the resident's risks of falling. All healthcare assistants utilise transfer belts to minimise resident harm from falls.</p> <p>Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections and hazard management. The facility has achieved tertiary level ACC Workplace Safety Management Practice (WSMP).</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>	<p>PA Low</p>	<p>The service collects data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. However, not all pressure injuries were reported through the incident management system. The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. The incidents forms are then reviewed and investigated by the registered nurse. If risks are identified, these are processed as hazards using a hazard identification form.</p> <p>A discussion with the facility manager has confirmed her awareness of statutory requirements in relation to essential notification. A section 31 notification was made on the day of the audit relating to the recently healed externally acquired stage III pressure injury.</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</p>	<p>PA Moderate</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Five staff files were reviewed (two health care assistants, the acting clinical manager, one registered nurse and the activities coordinator). Evidence of signed employment contracts, job descriptions, orientation and training were available for sighting. Annual performance appraisals for staff were completed in files sampled. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with care staff described the orientation programme that includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in-service schedule is implemented</p>

legislation.		and attendance is recorded. All staff complete a range of competency assessments. Four of eight registered nurses have completed their interRAI training. There is not always a staff member on duty with a current first aid/CPR certificate.
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 service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The facility manager is an enrolled nurse (practicing certificate has not been maintained) and the clinical manager is a registered nurse. A minimum of one RN is rostered on duty 24 hours a day, 7 days a week.  Staff reported that staffing levels and the skill mix was appropriate and safe. All families and residents interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.
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	Medications are checked against the doctor's medication profile on arrival from the pharmacy by a registered nurse. Any mistakes by the pharmacy are regarded as an incident.  Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Two registered nurses were observed safely and correctly administering medications. Not all prescribed medications on charts reviewed had been signed as administered.  Resident medication charts are identified with demographic details and photographs. The medications fridges are monitored daily. All 10 medication charts had allergies (or nil known) documented. One resident had copies of prescriptions and more than one medication chart.  All medications are stored appropriately and regular weekly checks have occurred for 'as required' medications. Routine weekly checks for regular controlled drug medications have not occurred.  There are three residents who self-administer medications. Not all evidenced a completed competency assessment.  Nine of ten (one resident had been at the service less than three months) medication charts reviewed identified that the GP had reviewed the resident three monthly and the medication chart was signed. Not all charts documented start dates for medications. All medication charts document the indication for giving the PRN medication. All eye drops were dated on opening.
Standard 1.3.13: Nutrition, Safe Food, And	FA	The service has a large workable kitchen. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four

<p>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>weekly menu in place that is designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.</p> <p>Food safety information and a kitchen manual are available in the kitchen. Food served on the day of audit was hot and well presented.</p> <p>The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.</p> <p>The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean.</p> <p>Kitchen staff have been trained in safe food handling.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The previous audit identified that not all files reviewed contained interventions in the care plans and not all were detailed. The five files reviewed for this audit demonstrated that in two of five files sampled, all identified areas of need were addressed in the care plan in sufficient detail to guide staff. The previous shortfall continues to require improvement.</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 desired outcomes.</p>	<p>FA</p>	<p>Wound care plans, infection control plans, fluid balance management plans and pain management plans were evident. The use of short-term care plans was evident. In all files sampled and following observation and interviews with staff and residents; the residents are receiving care that meets all their needs. The GP interviewed stated the facility applied changes of care advice immediately and was complimentary about the quality of service delivery provided. Resident's needs are assessed prior to admission and resident's primary care is provided by the facility GPs unless the resident chooses another GP.</p> <p>Dressing supplies are available and a treatment room is stocked for use.</p> <p>Continance products are available and resident files include a urinary continence assessment, bowel management and continence products identified for day use, night use and other management.</p> <p>Specialist continence advice is available as needed.</p> <p>Wound assessment and wound management plans were in place for ten residents including two pressure injuries (one grade I and one grade II). There is evidence in files of the wound specialist referrals. Wound care is completed within timeframes.</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>There is an activity officer who works in the facility across both service levels. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family.</p> <p>Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life.</p> <p>All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.</p> <p>Five resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review.</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>All initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is evaluated at least six monthly or earlier if there is a change in health status. There is at least a three monthly review by the GP. All (with one exception – link 1.3.5.2) changes in health status are documented and followed up. Care plan reviews are signed by a registered nurse. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</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>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry date 1 July 2016). There are implemented processes for preventative and reactive maintenance and all areas appear well maintained. All rooms are currently being refurbished as they are vacated (link 1.1.13).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection</p>	<p>FA</p>	<p>The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly - including urinary tract, upper respiratory, skin and infections that do not require antibiotics. This is an improvement since the previous audit. This data is reported to the facility meetings. Monthly data</p>

<p>is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed.</p> <p>There were three residents with enablers in the form of bed rails. These were requested by the residents. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of one of the files of a resident using an enabler.</p> <p>There were two residents using restraints.</p>

## Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.1</p> <p>The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code.</p>	PA Low	<p>There are appropriate policies around complaint management and these were implemented for all except one complaint. A corrective action plan to manage issues identified in the complaint was developed during the audit.</p>	<p>One complaint via the Health and Disability Commissioner did not demonstrate evidence of response to the complainant, investigation or development of a corrective action plan at the time of the complaint.</p>	<p>Ensure that the complaints management policies and procedures and legislative requirements are met for all complaints.</p>

				90 days
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	The clinical manager and two registered nurses interviewed were knowledgeable about the requirement to complete incident forms for pressure injuries. There was evidence of two previous pressure injuries being reported through the incident management system.	Two stage II pressure injuries identified in December 2015 did not have incident forms completed.	<p>Ensure that all pressure injuries are reported through the incident reporting and management system.</p> <p>90 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	There is an implemented education programme for registered nurses and healthcare assistants. The organisation plans for all registered nurses to complete a first aid certificate, to ensure there is a staff member on duty at all times with a first aid certificate. This has not occurred.	The service has not ensured that there is not at least one staff member on duty at all times with a current first aid certificate.	<p>Provide evidence that there is at least one staff member on duty at all times with a current first aid certificate.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing,</p>	PA Moderate	All medications are administered by medication competent staff. Not all have documented as administered as prescribed. GP's complete medication prescription charts three monthly and eight of ten charts have start dates for medications documented on the pharmacy generated chart that is signed by the doctor. One resident sees several doctors including specialists and not all medications	<p>(i) Controlled drug checks for regularly prescribed drugs have not had weekly checks completed.</p> <p>(ii) Two of ten medication charts sampled did not have start dates recorded for medications.</p> <p>(iii) One resident has two different medication charts and copies of three prescriptions for medications which are not recorded on either drug chart, making it difficult to ascertain what and when</p>	<p>(i) Ensure weekly checks occur for all controlled drugs.</p> <p>(ii) Ensure start dates</p>



<p>dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>are documented on one prescription chart. All controlled drugs that are kept for stock use or prescribed 'as required' are checked weekly by two staff but regular controlled drugs are not.</p>	<p>medication is due to be administered. (iv) Two of ten medication administration records sampled, do not have all prescribed medications signed as administered.</p>	<p>are recorded for all medications. (iii) Ensure each resident has all medications recorded on one medication chart. (iv) Ensure all medications are administered as prescribed.  60 days</p>
<p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>There are policies and procedures around the management of medications for residents who self-administer. Three residents partially self-administer medications and all have safe areas to store medications in. One of the three residents had a competency assessment completed around self-administration of medication.</p>	<p>Two of three residents who self-administer medication did not have a competency assessment completed.</p>	<p>Ensure all residents who self-administer medication have regular competency assessments completed.  90 days</p>
<p>Criterion 1.3.3.3</p>	<p>PA Low</p>	<p>Registered nurses interviewed were aware of</p>	<p>(i) One of five files sampled (a hospital resident) did</p>	<p>(i) Ensure</p>

<p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>contractual requirements around interRAI. A reported turnover of interRAI trained registered nurses and a delay in the availability of training are reported to have made these requirements difficult to meet and one file sampled had not met contractual interRAI requirements. Two of five files sampled had paper based assessments reviewed within timeframes late in 2015 and one file reviewed was not yet due for the risk assessments to be reviewed.</p>	<p>not have an interRAI assessment completed on admission.</p> <p>(ii) Two of five files sampled (both rest home) had not had risk assessments reviewed in the past six months.</p>	<p>contractual timeframes are met around interRAI.</p> <p>(ii) Ensure all risk assessments are reviewed (using the interRAI tool) at least six monthly.</p> <p>90 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Care plans are completed by registered nurses using a template document. Staff have received training around documentation and care planning and all resident files contained a care plan. However, not all care plans addressed all identified needs.</p>	<p>Three of five care plans sampled did not document interventions for all identified needs in the care plan. (a) Hospital resident: The use of Ensure and the need for a fortnightly weigh were not documented in the care plan. (b) Rest home resident: The management of diabetes was not sufficiently detailed in the care plan and does not include blood sugar ranges or the management of hypo and hyper glycaemia. Pain management and falls risk management were not addressed in the care plan. (c) Rest home resident: The risks associated with warfarin use, the use of Ensure, falls risk and dietary needs were not addressed in the care plan.</p>	<p>Ensure that interventions are entered into care plans, and contain sufficient details to guide staff.</p> <p>60 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.