

Lyndale Care Limited - Lyndale Villa and Manor

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Lyndale Care Limited
Premises audited:	Lyndale Villa Lyndale Manor
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 6 September 2016 End date: 7 September 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:	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

Lyndale Care provides rest home and dementia level care in two separate facilities (the Villa and the Manor respectively), which are located 250 meters apart in Masterton, for up to 56 residents. The service is operated by Lyndale Care Ltd, a privately owned company, and managed by a general manager who is supported by a quality manager and lead registered nurse. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, and a general practitioner.

This audit has identified areas requiring improvement relating to medication, progress notes and care plans.

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.	Green	Standards applicable to this service fully attained.
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The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

A Maori health plan is in place to ensure residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. Care is guided by a comprehensive health plan and related policies. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has strong linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

The general manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been generally resolved promptly and effectively.

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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Lyndale Care Ltd is the governing body and is responsible for the service provided at this facility. A business strategic plan and a quality and risk management plan are documented and include the purpose, scope, direction, goals and objectives, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular weekly meetings with the owner and formal reporting by the manager at the governance meetings which are held quarterly.

The facility is managed by an experienced and suitably qualified manager who has been in the role for 22 years. A quality and risk management system is in place which includes an annual calendar of internal audit activity, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the governance and staff meetings, with discussion of trends and follow up where necessary. Meeting minutes and graphs of clinical indicators are displayed. Adverse events are documented on accident/incident forms and seen as an opportunity for improvement. Corrective action plans are being developed, implemented, monitored and signed off. Informal and annual formal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is up to date.

A suite of policies and procedures covering the necessary areas, are current and reviewed regularly.

The human resources management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan facilitate and record ongoing training supports safe service delivery, and includes regular individual performance reviews. Registered nurses (RNs) are encouraged to undertake post graduate and other study relevant to their role.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. There is a roster of RNs on call out of hours.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people. Up to date, hard-copy and integrated residents' records are maintained.

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 low risk.
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The organisation works closely with the local Needs Assessment and Service Co-ordination Service to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are comprehensively assessed by the multidisciplinary team on admission. Registered nurses are on site eight hours each weekday and three hours on weekend days at the Manor, and seven hours daily at the Villa, with an additional 21 hours of registered nursing time available each week to relieve staff for completing assessments and planning care. These nurses are supported by care and allied health staff, including a pharmacist and a designated general practitioner. Shift handovers and detailed progress notes guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a qualified diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are generally managed according to policies and procedures based on current good practice and consistently implemented using a manual medication charting system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food policies guide food service delivery, supported by staff with food safety qualifications. The kitchens were well organised, tidy and clean. Residents confirmed satisfaction with meals.

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 Villa is an older style building while the Manor has been designed and largely rebuilt specifically to respond to the needs of residents with dementia. All rooms are single occupancy, the majority with ensuite bathrooms, and all are of adequate size to provide the level of personal care required.

All building and plant complies with legislation and current building warrants of fitness were displayed. A preventative and reactive maintenance programme is implemented.

Communal areas are all spacious and maintained at a comfortable temperature. A range of shaded external areas with seating are available.

Implemented policies guide the management of waste and hazardous substances. Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment are safely stored. All laundry is undertaken onsite at both the Villa and the Manor with systems monitored to evaluate effectiveness.

Emergency procedures are documented and displayed. Regular fire drills are completed and there is a sprinkler system and call points installed in case of fire. Access to emergency power sources are available. Residents report a timely staff response to call bells. Appropriate security arrangements are in place to ensure the safety of all residents.

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 organisation has implemented policies and procedures that support the minimisation of restraint. No enablers or restraints are in use at the time of audit. The Villa and the Manor are restraint free environments. Restraint would only be used as a last resort when all other options have been explored. Any enabler use would be voluntary for the safety of residents in response to individual requests. Staff receive training at orientation and thereafter every two years, including all required aspects of restraint and enabler use, alternatives to restraint and dealing with difficult behaviours. Staff demonstrated knowledge and understanding of the restraint and enabler processes.

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.
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The infection prevention and control programme aims to prevent and manage infections. The newly-appointed infection control coordinator is an experienced registered nurse. Specialist infection prevention and control advice is able to be accessed from the district health board. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken and analysed, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	42	0	3	0	0	0
Criteria	0	87	0	3	0	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Lyndale Care Limited has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and in ongoing training, as was verified in training records.</p>
<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>Nursing and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures, primary medical care, personal and nursing care and collection of personal and health information</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's clinical file. Staff demonstrated their understanding by being able to explain situations when this may occur.</p>

		Staff were observed to gain consent for day to day care on an ongoing basis.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service, and how the service would support residents/family members to access this should this be required.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of the Spark of Life.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Residents who wish to visit and even stay overnight with family are supported to do so if they are well enough. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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 complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available in a both facility reception areas and in resident information booklets.</p> <p>The complaints register reviewed showed that four complaints have been received this year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and improvements have been made where possible.</p> <p>The general manager (GM) is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Residents and/or family members interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) during discussions with senior</p>

<p>Consumers are informed of their rights.</p>		<p>management and registered nurses as part of the admission process, and also being provided with this information in hard copy form. The Code is displayed in the reception areas together with information on advocacy services, how to make a complaint and feedback forms. Residents were offered the opportunity in a recent resident's meeting to discuss any queries they had in relation to their rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff understood the need to maintain privacy and were observed doing so throughout the audit (eg, when attending to personal cares, including when bathrooms were being used, ensuring resident information is held securely and privately, and when sharing verbal information during staff handovers). All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by continuing their involvement in family and community activities as they chose. Each plan included clear and detailed documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There are currently no residents in the service who identify as Māori. A Māori health plan has been developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. There is also a staff member who identifies as Māori and is available to support other staff as required. A registered nurse advised that rooms are always blessed after a resident dies.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's</p>	<p>FA</p>	<p>Residents and family members verified that they were consulted on individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed, and there was evidence of resident/family</p>

<p>Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>input into the development of these plans.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner also expressed satisfaction with the standard of services provided to residents.</p> <p>The induction process for staff includes education related to professional boundaries and expected behaviours. Staff are provided with guidelines in relation to expected conduct in both their job descriptions and their individual employment contracts, and this is discussed with them during the orientation process. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, staff demonstrated a clear understanding of what would constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, physiotherapist, wound care specialist, community dieticians, services for older people, psychogeriatrician and mental health services for older persons. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks, such as a forthcoming infection control study day, to support contemporary good practice. A registered nurse is also currently undertaking post graduate study in relation to care for residents with dementia.</p> <p>Other examples of good practice observed during the audit include initiatives to reduce the incidence of falls. Residents who require specialist dementia care now have personalised information easily accessible in their rooms to help guide with de-escalation of behaviour should this be required.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, They were advised in a timely manner about any incidents or accidents and the</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services are able to be accessed via the District Health Board when required. Staff knew how to do so, although the registered nurse advised these services were seldom required as residents usually speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The business strategic plan is reviewed annually, outlines the purpose, values, scope, direction and goals and mission of the organisation. The documents describe both annual and longer term objectives. The general manager provides a quarterly report against the objectives to the owners. A sample of reports reviewed shows adequate information to monitor performance is reported including occupancy rates, quality measures, staffing and any emerging risks and issues.</p> <p>The service is managed by a GM who has an administrative background and holds a relevant qualification in healthcare management. She has been in the role for 21 years. She is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The GM confirms knowledge of the sector, regulatory and reporting requirements. The GM is supported by the quality manager and a registered nurse (RN) team who meet weekly.</p> <p>The service holds contracts with the DHB for rest home, dementia and respite care services. Forty one (41) residents are receiving services under the contract (23 rest home and 18 dementia) at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>When the GM is absent, the quality manager who has previously managed aged care facilities, carries out all the required duties under delegated authority. The owner is also available as necessary. During absences of the lead RN, the clinical management is overseen by one of the other RN's who are both experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk</p>	<p>FA</p>	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement</p>

<p>Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>and is understood by staff. This includes management of incidents and complaints, audit activities, resident and family satisfaction surveys, health and safety issues, clinical incidents including infections and falls.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on quality matters. Regular review and analysis of quality indicators occurs and related information is reported and discussed at the clinical, governance and staff meetings. Minutes reviewed include discussion on any pressure injuries, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through internal audit activities and also at the staff meetings. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. The last survey showed a general satisfaction with the services provided.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies through the regular staff meetings and newsletters.</p> <p>The quality manager described the processes for the identification, monitoring and reporting of risks and development of mitigation strategies. The risk register shows regular review and updating of risks, risk plans and the addition of new risks. The quality manager is aware of, and attended training, in the Health and Safety at Work Act (2015) requirements and confirmed all requirements are in place.</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>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed show these are fully completed, incidents are investigated, action plans developed and actions are followed-up in a timely manner. Adverse event data is collated, analysed and reported to clinical and staff meetings and minutes reviewed show discussion in relation to action plans and improvements made.</p> <p>Policy and procedures described essential notification reporting requirements for pressure injuries, health and safety, human resources, infection control, the coroner, and to the DHB. The GM advised there have been no notifications of significant events made to the Ministry of Health since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>Policies and procedures, in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>tasks and accountabilities for the various roles. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systematically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a 'buddy' through their initial orientation period. Staff records reviewed show documentation of completed orientation and a performance review completed annually.</p> <p>Continuing education is planned on a two yearly basis with a detailed annual training plan developed. Mandatory training requirements are defined and scheduled to occur over the course of the year. Care staff have either completed or commenced a New Zealand Qualifications Authority education programme to meet the requirements of the provider's agreement with the DHB. The quality manager is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education. Education records reviewed demonstrated completion of the required training. Staff reported that the annual performance appraisal process provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Appraisals were current for all staff.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mixes in order to provide safe service delivery. The facility adjusts staffing levels to meet the changing needs of residents if needed. The minimum number of staff is provided during the night shift and consists of two caregivers at each sites. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported adequate staff were available and that they were able to complete the work allocated to them. This was further supported by residents and family interviewed. Observations and review of a two week cycle sample during this audit confirmed adequate staff cover has been provided. The organisation uses its casual pool for short notice roster gaps. At least one staff member on duty has a current first aid certificate and there is a RN either on duty or on call 24 hours, seven days a week.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible</p>	<p>PA Low</p>	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. The names and designations of staff making entries into residents' progress notes were not always legible. Electronic</p>

when required.		<p>records, such as the interRAI assessments, were password protected and available only to designated staff.</p> <p>Archived records are held securely on site and are readily retrievable. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with the general manager or quality manager. They are also provided with written information about the service and the admission process. The organisation seeks updated information from the NASC Service or the general practitioner for residents accessing respite care.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records and a summary of nursing care requirements is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility confirmed that appropriate information accompanied the resident to promote continuity of care. The resident's family member reported being kept well informed during the transfer of their relative.</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>	PA Low	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed for both the rest home and dementia service during the two days of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a senior staff member against the prescription. All medications, except for some eye drops and one tube of ointment were within current use by dates. Clinical pharmacist input</p>

		<p>is provided at least six-monthly, with the most recent pharmacy controlled drug check and drug chart audit being completed within the past month.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range. Medications stored in one of the food fridges in the dementia service are stored in a sealed container, with the exception of two vials of medication.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review are not consistently recorded.</p> <p>No residents were self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to a registered nurse and recorded on an accident/incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p> <p>The service does not use standing orders.</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 food service is managed on each site by a cook with support from other kitchen staff.</p> <p>The menu follows summer and winter patterns and was in the process of being reviewed by a qualified dietitian at the time of the audit visit.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. Both main cooks have safe food handling qualifications, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their</p>

		meal in an unhurried fashion and those requiring assistance had this provided. There is sufficient staff on duty in the dining rooms at meal times to ensure assistance is available to residents as needed.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with two registered nurses. There is a clause in the access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Information is documented using the validated assessment tool interRAI as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by one of the two trained InterRAI assessors on site. Refer also to criterion 1.3.3.3.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, activities notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.
<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>	FA	Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and care is of an appropriate standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.

<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 activities programme is managed by a qualified diversional therapist who holds the national Certificate in Diversional Therapy. The therapist is assisted by two other staff members, one of whom is also working towards the national Certificate in Diversional Therapy.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three-monthly and as part of the formal six monthly care plan review.</p> <p>Two separate activities programmes are developed – one for the rest home and the second for the specialist dementia service. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples for the rest home include exercises, quizzes and word games, darts, bowls, outings, entertainers, and frequent outings such as joining with other aged residential care facilities for dancing, quizzes and games. The activities programme is discussed at the minuted residents' meetings and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and relevant.</p> <p>Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes games such as table tennis, ball games, tactile activities and craft, music, memory boxes and outings in the facility van. Care delivery staff also take responsibility for offering activities to residents when the diversional therapy staff are not on-site, and evidence was sighted of detailed records related to those activities.</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>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed in relation to resident progress towards the planned objective, and evaluated at least weekly, and/or as clinically indicated. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any</p>

		resulting changes. Following the six-monthly evaluation of care plans, the registered nurse sends a letter to that resident's family, advising them of the outcomes of the evaluation. Refer also to criterion 1.3.3.1.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents may choose to use another medical practitioner. Family members are advised when the next doctor's visit is scheduled so that they can be present if they wish. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the wound care specialist nurse and the diabetes specialist nurse. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances were in place. Infection control documentation includes a waste management section detailing procedures for waste (blood and bodily fluids) management and disposal.</p> <p>The doors to the cupboards storing chemicals were secured and containers labelled. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored and staff interviewed knew what to do should any chemical spill/event occur. Any related incidents are reported in a timely manner.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this, including the care, cleaning and laundry staff.</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	<p>A current building warrant of fitness at both facilities expires on 30 June 2017 and both are publically displayed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose. There is a proactive and reactive maintenance programme and buildings, plant and equipment are maintained to an adequate standard. The testing and tagging of equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews</p>

		<p>with personnel and observation of the environment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting. The environments are conducive to the range of activities undertaken in the areas. Efforts are made to ensure the environments are hazard free and that residents are safe. Residents interviewed confirmed they are happy with their environment and enjoy getting outside in the summer months.</p>
<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	<p>There is a mix of toilet, showers and bathing facilities. This includes a majority of rooms with en-suites, a small number of shared bathrooms between rooms and a large additional bathroom at each facility. There are also adequate numbers of accessible toilets throughout the facilities. Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, walking frames and wheel chairs. Staff and residents reported the adequacy of bedrooms. Mobility scooters are stored in a designated area outside and do not impede walkways or create a hazard for other residents.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>A number of communal areas are available for residents to engage in activities. The dining and lounge areas at both sites are spacious and enable easy access for residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to each of the settings and resident needs and is arranged in a manner which enables residents to mobilise freely.</p>
<p>Standard 1.4.6: Cleaning And</p>	FA	<p>All laundry is undertaken at each site in a dedicated laundry, except for soiled laundry at the Manor</p>

<p>Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>		<p>which is handled and transported appropriately to the Villa for laundering. Resident's personal items are laundered on site or by family members if requested. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner. The laundry is currently washed by dedicated laundry and cleaning staff, who both demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. The cleaning/laundry staff have received appropriate training.</p> <p>Chemicals were stored in locked areas and were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plans were approved by the New Zealand Fire Service on 28 April 2009 for the Villa and 23 March 2012 for the Manor. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 16 April at the Villa and 17 May at the Manor. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies at each site for use in the event of a civil defence emergency, including food, blankets, torches and gas BBQs, were sighted and meet the requirements for the number of residents at the Villa and the Manor. Water storage tanks are located in the roof spaces, and there is a generator at both sites.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on an informal basis and residents and families reported staff respond promptly to call bells. This was also observed to be the case during the audit.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked and checked by the afternoon staff at a predetermined time and all staff wear monitored individual alarms at night.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	FA	<p>All residents' rooms and communal areas have opening external windows. Electric heating provided is provided with a mixture of panel heaters or heat pumps in all rooms and bathrooms, with additional heat pumps and night store heaters in the communal areas. Areas were warm and well ventilated at both sites throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>A registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in the infection control manual. Infection control matters, including surveillance results, are discussed weekly at the clinical meeting, reported monthly to the general manager and facility owner, and are a standing agenda item at the monthly staff meetings. As appropriate for the size of the two facilities, there is no separate infection control committee, but relevant staff, such as representatives from food services and household management, can easily meet on an as-required basis.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control coordinator is an experienced registered nurse, who has been in the role for one month, and is booked to attend an infection control study day in October 2016. They are supported in this role by the quality manager, who has extensive experience in infection control analysis and reporting. Well-established local networks with the infection control team at the DHB are in place and expert advice from the community laboratory is available if additional support/information is required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections. The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are</p>	FA	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in February 2016 and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves, as appropriate to the setting. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and</p>

<p>implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>practices.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Priorities for staff education related to infection control are included in the annual education plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, using disposable tissues rather than handkerchiefs, and increasing fluids during hot weather.</p>
<p>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.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal and respiratory tract. When an infection is identified, a record of this is documented in the infection reporting form and clinical record. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the GM and the owner. The service is currently exploring options to further extend the analysis and trending of surveillance data.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the monthly staff meetings, as confirmed in meeting minutes sighted and interviews with staff.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is new to the role but has had significant previous experience and will provide support and oversight for enabler and restraint management in the facility. She has a sound understanding of the</p>

<p>of restraint is actively minimised.</p>		<p>organisation's policies, procedures and practice for the role and responsibilities.</p> <p>The facilities are both restraint free and on the day of audit, there were no residents who were using enablers. A robust process is in place should any residents request enablers which will ensure the on-going safety and wellbeing of the resident.</p> <p>Staff interviewed were clear about the process required for any enabler use that may be requested and the requirement for the least restrictive option to be used to meet the needs of the resident.</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 1.2.9.9</p> <p>All records are legible and the name and designation of the service provider is identifiable.</p>	PA Low	<p>Resident’s progress notes are updated every shift and contained clear, legible and detailed information. In approximately one-fifth of these entries, the name and/or designation of the staff member making the entry was not legible, and/or the designation clear. The service maintains a register of staff signatures that is filed in the medication folder, but even after reference to the current register the facility manager and quality manager had difficulty identifying two signatures/designations from entries in resident progress notes. They advised that a third name which was also unable to be identified was that of a staff member who had since left, and the specimen signature log for that period had been inadvertently destroyed.</p>	<p>The names and designations of staff making entries into residents’ progress notes are not consistently legible and/or designation is not clear.</p>	<p>The names and designations of staff making entries into the clinical records are legible and clear.</p> <p>180 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>	<p>PA Low</p>	<p>With the exception of three areas detailed below, all aspects of medicine management comply with legislation, protocols and guidelines. Medication charts are clear and legible, and include the resident's photo and their allergy status. Medication charting was consistent with requirements, except that ten of the seventeen medication charts reviewed did not contain evidence of the required three-monthly medical review of medication.</p> <p>The storage of medications not requiring refrigeration was safe and appropriate. In the rest home, medications requiring refrigeration were stored in the dedicated medication fridge. In the dementia service, medications requiring refrigeration are stored in one of the kitchen fridges. The majority of this medication was kept in a sealed container, but two vials of medication were on a separate shelf, and not in a container. The temperatures of both fridges was checked daily.</p> <p>The registered nurse advised that regular checks are undertaken to ensure that medications are within current use-buy dates, The date of first use of eye drops was not recorded on three containers of eye drops in current use, while a fourth container had not been discarded within one month of first use. One tube of ointment in the medication trolley was also outside its expiry date. All other medications on both sites were within current use-by dates.</p>	<p>There is inconsistent evidence of three-monthly reviews of medications.</p> <p>The date of first use of eye drops is not always recorded or eye drops discarded within one month of first use.</p> <p>Medications stored in a food fridge were not kept in a separate container.</p>	<p>Three-monthly medication reviews are documented.</p> <p>Eye drops are dated when first used, and discarded within one month.</p> <p>Medications are stored within a sealed container if kept in a fridge which also contains food.</p> <p>180 days</p>
<p>Criterion 1.3.3.3</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>PA Low</p>	<p>Registered nurses are responsible for assessment, planning, care delivery, evaluation and review. Initial assessments and care plans had been developed within 24 hours in all ten resident records reviewed. The service recently experienced some staffing disruptions, which resulted in delays to interRAI assessments and care plan development. All residents had a current interRAI assessment at the time of the audit. In three instances these assessments and the subsequent development of the care plan had not been completed within three weeks of admission. InterRAI reassessments are required six monthly, or earlier if clinically indicated. In three instances, reassessments had not</p>	<p>The development of lifestyle care plans and interRAI assessments/reassessments are not completed within required timeframes.</p>	<p>All aspects of service provision are consistent with contractual requirements and as clinically indicated.</p>

		been completed within those timeframes. Medical admissions and medical reviews were all consistent with contractual requirements.		180 days
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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.