

The Whalan Lodge Trust

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: The Whalan Lodge Trust

Premises audited: Whalan Lodge

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 11 October 2016 End date: 11 October 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: 7

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

General overview of the audit

Whalan Lodge is a 14-bed rest home, which is owned and governed by a community trust board. On the day of the audit, there were seven residents. The new manager at Whalan Lodge has been in the role for one month and is supported by an assistant manager and a new part time registered nurse. Family and residents interviewed spoke positively about the care and support provided.

This surveillance audit was conducted against the health and disability sector standards and the district health board contract. The audit process included the review of policies and procedures, the review of resident and staff files, observations and interviews with residents, a family member, staff and management.

The service has addressed one of six findings from the previous audit around evaluation of care plans. Further improvements are required in relation to professional development for the manager, employment processes, assessments, and aspects of the food service.

This audit also identified that improvements are required around the quality programme, incident reports, education and training for staff, progress notes, activities plans, and medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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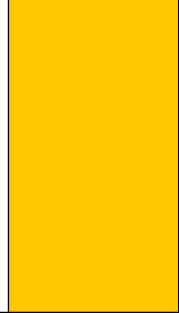
Communication with residents and family was evidenced in care plans and confirmed on interviews. Complaints and concerns have been managed and a complaints register is maintained.

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.
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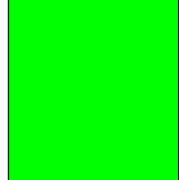
The Whalan Lodge community trust board provides governance and support to the manager. There is a documented quality programme. Internal audits are completed as per the audit schedule. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are appropriately managed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The residents and family interviewed confirmed their input into care planning and access to a typical range of life experiences and choices. The care plans reviewed were consistent with meeting residents' needs. Initial care plans are documented on admission. Risk assessments are completed and reviewed six monthly. Where progress was different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan. Care plans are evaluated six monthly. Activities were provided either within group settings or on a one-on-one basis. Medication policies reflect current guidelines. Nutritional needs of residents are provided in line with resident needs and residents commented positively on the food service provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Whalan Lodge has a current building warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

Whalan Lodge has restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, there was no residents with restraint or enablers.

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.

The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	8	0	6	3	0	0
Criteria	0	26	0	10	4	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	A complaints policy and procedures are in place. Residents/family can lodge formal or informal complaints through verbal and written communication, resident meetings, and complaint forms. Information on the complaints forms includes the contact details for the Health and Disability Advocacy Service. Complaints forms are available at the entrance. The service has a complaints register. No complaints have been received since the previous audit. A complaints procedure is provided to residents within the information pack at entry.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Policies are in place relating to open disclosure. Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Family are notified of incidents and accidents, and changes in resident condition. One relative interviewed confirmed they are notified of any changes in their family member's health status. The manager and staff were able to identify the processes that are in place to support family being kept informed. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.

conducive to effective communication.		The facility has an interpreter policy to guide staff in accessing interpreter services. Residents (and their family/whānau) are provided with this information at the point of entry. Families are encouraged to visit.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	PA Low	Whalan Lodge is governed by a community trust board. The facility is situated in Kurow. The Whalan Lodge manager is new to the role having been with the service since February 2016 in the capacity of supporting an interim manager (now assistant manager/activities person). The new manager took over the management role in September 2016. He has a background in education, and corporate management. The manager reports to the governing board on a monthly basis on a variety of topics relating to quality and risk management. The manager is supported by the assistant manager/activities person, a part time registered nurse, care staff, the trust board and volunteer members of the community. The service has a current strategic and business plan, which includes a philosophy of care, and a current quality and risk management plan. The quality management system requires further implementation (link 1.2.3.6). The manager has not completed professional development in relation to managing a rest home. The previous audit finding remains unmet.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	The business plan and quality programme describe Whalan Lodge's quality improvement processes. The risk management plan describes objectives, management controls and assigned responsibility. An annual review of the previous year's quality programme has been completed. Not all quality activities for 2016 have been implemented. Quality assurance/management and staff meetings have been held. Minutes for these meetings held include actions to achieve compliance where relevant. Discussions around quality activities are not included as part of the staff meetings. Resident/relative meetings have been held however, resident meeting minutes could not be located. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is an internal audit schedule, which has been completed. Areas of non-compliance identified through quality activities are actioned for improvement however, not all corrective actions have been completed. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/procedures to support service delivery which have been provided by an external consultant. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly and updated externally. Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Resident surveys have not been completed since 2014.
Standard 1.2.4: Adverse Event Reporting	PA Low	There is an accidents and incidents reporting policy. Accidents and near misses are investigated by the registered nurse and analysis of incident trends occurs. There is a discussion of incidents/accidents at quality assurance/management meetings including actions to minimise recurrence. Clinical follow-up of residents is

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.		conducted by either the registered nurse (when on duty or on-call) or by a member of the local medical centre. The service has 24-hour access to the medical practice team including a general practitioner (GP) and/or a PRIME trained registered nurse, or ambulance personnel. Discussions with the manager confirms that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. On review of incident reports for July, August and September 2016, and corresponding residents' progress notes and files, there is evidence that residents have received timely and appropriate care following an incident. The registered nurse reviews all incident reports and signs them off. Not all incidents have been investigated for opportunities for manage all risks.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Moderate	There are human resource management policies in place, which includes recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of the registered nurse's practising certificate is kept. Six staff files were reviewed, including the manager, assistant manager, registered nurse, cook and two caregivers. None of the six staff files reviewed evidenced that full employment documentation was in place. The manager and assistant manager advised that an orientation programme is provided to new staff. Not all staff files reviewed had signed contracts, completed orientation documentation, a signed job description or an annual appraisal. The previous audit findings remain unmet. The in-service education programme for 2015 was not able to be reviewed. The programme for 2016 has not been fully completed. The service facilitates caregivers to complete an on-line caregiver training programme. Not all staff have a current first aid certificate. Six monthly fire evacuation drills have not been conducted.
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 policy that includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the rest home residents. At least one staff member is rostered on at any one time with one staff on-call. The registered nurse and a registered nurse from the local medical centre (both trained in primary response in a medical emergency PRIME) share on-call after hours and weekends. The manager works at the service in the afternoons Monday to Thursday and all day Friday. Advised that extra staff can be called on for increased resident requirements. Interviews with caregivers, residents and family identify that staffing is adequate to meet the needs of residents.

<p>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.</p>	PA Moderate	<p>The medicine management policies and procedures meet guidelines and current legislative requirements. In interview, the senior caregiver and assistant manager reported that prescribed medications were delivered to the facility and checked on entry by the registered nurse. Medications are stored securely. The controlled drug register was maintained and evidenced weekly checks and six monthly physical stocktakes. The medication fridge temperatures were conducted and recorded.</p> <p>Not all staff authorised to administer medicines had current competencies. The medication round was observed and evidenced the staff member administered and signed off, as the dose was administered. Administration records were maintained, as were specimen signatures. Staff education in medicine management has not been provided in the past 12 months for all staff (link 1.2.7.5).</p> <p>Not all medication prescription orders were signed by the GP, and not all three monthly medicine reviews were recorded on the medication charts. Residents' photo identification was not evident on all charts. One resident is self-administering medications, however, the required assessment and competency of the resident was not current.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	PA Low	<p>The food service policies and procedures are appropriate to the service setting. A seasonal menu has been reviewed by a dietitian. The cooking is completed by a new cook, volunteers and care staff. The cook has yet to complete food safety training. The cook advised that the kitchen staff are made aware of the residents' individual dietary needs. There were copies of the residents' dietary profiles in the kitchen. The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided. The fridge and freezer temperatures have inconsistently been recorded. The surface in food preparation area and one in storage area have been repaired and now meet infection control requirements. Food temperatures are consistently recorded and decanted food is dated. The service has addressed this aspect of the previous finding.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Moderate	<p>The residents' needs, outcomes and goals were identified via the initial assessment process and these were recorded in five of five files reviewed. The facility has processes in place to seek information from a range of sources, (eg, family, GP, specialist and referrer). The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The residents' files evidenced residents' discharge/transfer information from DHB (where required) were available. Risk assessments have been completed and reviewed six monthly or as required. The service has addressed the previous audit finding. The InterRAI assessment tool has not been utilised to support the development on the long-term care plan. The registered nurse has not completed InterRAI training. Not all residents had an activities assessment completed. On interview, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations</p>

		of care.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	<p>The care being provided for residents is consistent with the needs of the residents, as evidenced through review of resident files, interviews with staff and residents and observation of practice. Residents who required registered nurse review following health concerns, have this recorded as 'having been done'. Relatives were notified of changes in a resident's condition as evidenced in progress notes, incident reports and family contact sheets. The registered nurse initiates a GP consultation for any changes in resident health status. Caregivers document any changes in care/condition of residents in the progress notes (link 1.3.3.4). The resident records reviewed were individualised and personalised to meet the assessed needs of the residents. The care was flexible and focused on promoting quality of life for the residents. All residents interviewed reported satisfaction with the care and service delivery.</p> <p>Wound assessments, wound management plans, short-term care plans and wound progress reports has been completed for residents with previous wounds. There were no current wounds on the day of audit. There were adequate dressing and continence supplies sighted on the day of audit.</p> <p>On interview, staff confirmed they were familiar with the current interventions of the residents. Monitoring records are completed for weight, observations, behaviours, and food and fluids.</p>
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.	PA Low	<p>In interview, the assistant manager/activities coordinator confirmed the activities programme met the needs of the service group and the service had appropriate equipment. The activities programme is provided by the activities coordinator, caregivers and volunteers. The activities programme includes activities of interest to the resident and is appropriate to their needs and abilities. Van outings are a regular feature and there is contact with the local community and school.</p> <p>Interviews with residents, family and staff confirmed the activities programme included ordinary unplanned/spontaneous activities including festive occasions and celebrations. Not all residents had individualised activities care plans in residents' files (link to activities assessment finding 1.3.4.2). The residents' activities attendance records were maintained.</p>
Standard 1.3.8: Evaluation Consumers' service delivery plans are	FA	Timeframes in relation to care planning evaluations are documented. The residents' files evidenced the residents' care plans were up-to-date and reviewed six monthly. In interviews, residents and family confirmed their participation in care plan evaluations. Care plan evaluations reviewed for five of five files recorded the degree of achievement to the intervention provided and progress towards meeting the desired outcomes. Activities care plans developed for two residents (link 1.3.7.1), have been evaluated six monthly. The service has addressed this

evaluated in a comprehensive and timely manner.		previous audit finding. Short-term care plans have been used in the sample of residents' files reviewed. There was recorded evidence of additional input from allied health, if this was required.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness expires on 1 August 2017.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance is an integral part of the infection control programme and is described in Whalan Lodge's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections are entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality/management meetings and at handover. If there is an emergent issue, it is acted upon in a timely manner.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were no residents using restraint or enablers on the day of audit. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Enabler use is voluntary. Restraint use audit has been conducted and restraint has been discussed as part of quality meetings. The registered nurse is the designated restraint coordinator.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.	PA Low	The Whalan Lodge community trust Board has employed a new manager, who has been in the role for one month. The manager reports to the trust board on a variety of issues and is supported by the board and chairman. The manager is new to aged care and has not attended professional development relating to managing a rest home. The services of an external consultant have been engaged to provide a comprehensive suite of policies and procedures. The consultant is available to the manager via phone and email.	The manager has not attended professional development relating to managing a rest home.	Provide evidence that the manager has completed at least eight hours of professional development relating to managing a rest home. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service	PA Low	The new manager is now responsible for the overall implementation of the quality programme. A quality plan for 2016 is in place. Quality activities are conducted with exception of completion of corrective actions (link 1.2.3.8) and discussion of quality information at staff meetings. Meeting minutes have been maintained for the	Quality activities have not been completed as follows: a) resident meeting minutes have not been maintained; b) staff meeting minutes do not include discussion with	Ensure that all aspects of the planned quality programme are completed, including maintaining meeting

providers and, where appropriate, consumers.		management meeting and staff meetings. The service has not conducted a recent resident survey.	staff around quality related activities and issues; and c) the resident survey has not been conducted in the past two years.	minutes, discussing quality outcomes at staff meetings and conducting an annual resident survey.
Criterion 1.2.3.8 A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.	PA Low	Corrective actions are documented following quality assurance/management meetings and following internal audits. Outcomes and completion of the corrective actions have not been completed for all internal audits.	Corrections actions identified through meeting minutes and internal audits (medication, cultural spiritual, activities programme and staff training) have not been fully implemented or documented as completed and signed off.	Ensure that all corrective actions are implemented, and signed off when completed. 90 days
Criterion 1.2.4.3 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.	PA Low	Incident reports reviewed included falls (four), one incident where a resident left the premises and one medication error. The care staff completed the report and included details of the incident and the immediate care and treatment provided. Forms and files, evidence that residents have been reviewed by either a GP or a registered nurse, post-incident. Observations and monitoring of the resident post-incident have been completed. The registered nurse reviews all incident reports and signs them off however, investigations into causation and analysis has not been documented.	Incident reports reviewed do not include investigation by the registered nurse into causative factors and required interventions to minimise risk and recurrence.	Ensure that all incidents are thoroughly reviewed to identify causative factors, and to identify opportunities to minimise risk 60 days
Criterion 1.2.7.3 The appointment of	PA Low	Eleven staff are employed at Whalan Lodge. Six staff files reviewed evidenced copies of qualifications. The two	i) Four of six staff do not have a signed employment	Ensure that all employment

appropriate service providers to safely meet the needs of consumers.		caregiver files reviewed included a completed caregiver training programme. Two of six files have a signed employment contract on file. Four of six files have signed job descriptions. Four of six staff files are not yet due for an annual appraisal.	contract on file including one caregiver, the registered nurse, the assistant manager, and the manager. ii) The registered nurse and manager do not have a signed job description on file.	documentation is completed and documented. 60 days
Criterion 1.2.7.4 New service providers receive an orientation/induction programme that covers the essential components of the service provided.	PA Low	The service has orientation processes in place including a buddy system for new staff members to work alongside more experienced staff. The orientation package includes health and safety, infection control and familiarisation with policies and procedures. Two of six staff files reviewed evidence that orientation packages and documentation have been completed.	Four of six staff files reviewed do not evidence that orientation packs have been completed, including the cook, the registered nurse, one caregiver and the manager.	Ensure that all new staff complete the orientation and induction programme and that this is recorded. 60 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	The caregivers are provided with the opportunity to complete an on-line caregiver training programme and there is a plan in place for the remainder of 2016. This has been facilitated since July 2016. Topics completed include hydration, infection control and medication. Further in-service education for all staff has not been provided in the past 12 months. A fire knowledge quiz has been completed.	In-service education has not been provided for all staff including six monthly fire drills, code of consumer rights, restraint, cultural safety, wounds and skin care,	Ensure that all educational requirements are provided in-line with the annual plan. 60 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review,	PA Moderate	Medicine charts evidenced that medicine charts were legible, 'as required' (PRN) medication identified indications for use, and discontinued medicines were dated and signed by the GPs. The residents' medicine charts recorded all medications a resident was taking (including name, dose, frequency and route to be given). Four of seven medication charts reviewed were fully	i) Three of seven medication files reviewed did not have all regular or 'as needed' medication orders signed by the GP. ii) Three of seven residents' medication charts did not	i) Ensure that all individual medication orders are signed for. ii) Ensure that three monthly GP reviews are recorded on the

storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		completed and signed by the GP, and three monthly reviews were documented by the GP for four of seven residents. Two of seven resident charts had photo ID.	evidence documented three monthly GP reviews. iii) Five of seven charts did not evidence photo identification of the resident.	medication chart. iii) Ensure that all resident medication charts have a photo identification attached. 60 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Medication competencies are to be conducted annually along with annual medication training (link 1.2.7.5). Caregivers, the assistant manager and the registered nurse are designated to administer medications. Competencies were last conducted in July 2015 and have not been completed for new staff employed since then. The caregiver observed on a medication round, completed the process appropriately, according to policy and procedures.	Medication competency documentation was not current for any of the staff responsible for medication administration in the sample of staff files reviewed.	Provide evidence that all staff responsible for medication administration have a current competency assessment completed. 30 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	One resident self-administers medications. The medication packs are stored securely. Advised by the care staff, that the resident is capable of self-administering and appreciates the independence that this affords. The staff check the packs daily to ensure that all medications have been taken. The resident has been assessed by the registered nurse as competent to self-administer. This has not been reviewed three monthly.	Self-medication assessment and competency for one resident has not been reviewed three monthly as per policy and medication guidelines.	Provide evidence that residents who wish to self-medicate are managed in line with policy and medication guidelines. 60 days
Criterion 1.3.13.5 All aspects of food procurement, production,	PA Low	Kitchen was observed to be clean and tidy. Staff conduct kitchen cleaning and sign off when this is completed. Interview with the new cook confirmed they have not	i) The cook has not completed safe food handling training. ii) Fridge	i) Ensure that the cook completes safe food handling

preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.		completed food safety training. Food preparation is the responsibility of the cook. Records of food temperatures reviewed evidenced daily recording of food temperatures. Decanted foods were dated. The fridge and freezer temperature recordings could not be located.	and freezer recordings have been recorded for two days only in October. Further records could not be located on the day of audit.	training. ii) Provide evidence that fridge and freezer temperatures are recorded. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.	PA Low	The registered nurse attends the service once per week. Another registered nurse from the local medical centre is also available to staff if required. Both nurses are available afterhours and are on-call. Progress notes reviewed were comprehensively completed by the caregivers with occasional entries by the registered nurse. There were no instances where registered nurses had not reviewed residents following incidents or episodes of ill health, therefore the risk is low.	There are infrequent entries by registered nurses into progress notes for five of five resident files reviewed.	Provide evidence that registered nurses are documenting the review of residents' cares, and entries in to progress notes by caregiving staff. 60 days
Criterion 1.3.4.2 The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.	PA Moderate	Initial assessments and initial care plans are conducted on admission. Five of five files reviewed evidenced that risk assessments have been completed prior to the development of long-term care plans and reviewed six monthly or as required. None of the five resident files reviewed had had an InterRAI assessment completed. Activities assessments were completed in three of five residents' files reviewed.	i) InterRAI assessments have not been completed for five of five resident files reviewed; and ii) activities assessments were not completed for two of five residents.	i) Ensure that the InterRAI assessment tool is completed for all residents and that the outcomes inform the care planning process; and ii) ensure that all residents have an activities assessment completed. 60 days

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>Activities are provided for residents and are appropriate to the resident's needs. Group and one-on-one activities are provided by the coordinator, caregivers and volunteers. Two of five residents reviewed had a documented activities plan in place.</p>	<p>Three of five residents reviewed did not have a documented activities plan in place.</p>	<p>Ensure that all residents have a documented activities plan in place. 90 days</p>
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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 audit.

No data to display

End of the report.