

# Lexall Limited

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## Introduction

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

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

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

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

The specifics of this audit included:

<b>Legal entity:</b>	Lexall Limited
<b>Premises audited:</b>	Lexall Care
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 16 November 2016    End date: 16 November 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	55

# Executive summary of the audit

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## 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

Lexall Care provides rest home and hospital (geriatric and medical) level care for up to 58 residents and on the day of the audit there were 55 residents. The service is managed by a clinical manager. The residents and relatives interviewed all spoke positively about the care and support provided.

The unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents' and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed four of the six findings from the previous certification audit around the complaints management system, satisfaction surveys and resident meetings, education and training, and restraint minimisation documentation. Improvements continue to be required around wound care documentation and medication management.

This surveillance audit identified that improvements are required in relation to open disclosure, policies and procedures, corrective action planning, reference checking, and care plans/InterRAI assessments.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.
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Families and residents interviewed reported that the communication with staff and management meets their needs. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Business goals are documented for the service with evidence of regular reviews. A system is in place for the collection and analysis of quality and risk data. The risk management programme includes managing adverse events and health and safety processes.

Residents receive appropriate services from qualified staff. An orientation programme and regular education and training are in place for staff.

Registered nursing cover is provided 24 hours a day, seven days a week. Residents report staffing levels are adequate to meet their needs.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Assessments, care plans and reviews are completed by a registered nurse. Each resident has access to an individual and group activities programme. The group programme is varied and interesting. Medication is stored appropriately in line with legislation and guidelines. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. Residents and relatives interviewed were complimentary about the food service.

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

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint policy and procedures are in place. A register is maintained by the restraint coordinator. The service had six hospital level residents using a restraint and four residents using enablers. Staff receive education and training in restraint minimisation and managing challenging behaviours.

## 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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Infection control management systems are in place to minimise the risk of infection to residents, service providers and visitors. 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. There have been no outbreaks since the previous audit.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	12	0	3	3	0	0
<b>Criteria</b>	0	34	0	4	3	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>Complaints forms are available at the entrance to the facility. Discussions with five residents (three rest home and two hospital) and families confirmed they were provided with information on the complaints process during their entry to the service. Residents and families also confirmed that they are comfortable speaking with the clinical manager/registered nurse (RN) if they have a concern and that any issue raised is addressed promptly.</p> <p>The complaints procedure is provided to residents and family during the resident's entry to the service. A register of complaints received is maintained by the clinical manager. Two complaints have been lodged in the register for 2016 (year to date). Each lodged complaint included evidence of acknowledgement, investigation and follow-up and were within the timeframes determined by the Health and Disability Commissioner (HDC). This is an improvement from the previous audit. Both complaints were signed off by the clinical manager as resolved.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	PA Low	<p>Policies and procedures relating to accident/incidents and open disclosure identify staffs' responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is supposed to be recorded on the accident/incident form and in the residents' progress notes but was missing in five of fifteen completed reports.</p> <p>Three families interviewed (one rest home and two hospital) stated that they are kept informed when their family member's health status changes or in the event of an accident/incident.</p>

<p>provide an environment conducive to effective communication.</p>		<p>Contact details of available interpreters are available. Staff and family assist as they are able. Communication aids with translated words were visible in relevant residents' rooms. The information pack is available in large print and is read to residents who require assistance.</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>Lexall Care is privately owned. It is managed by a full time clinical manager (RN). The service is certified to provide rest home and hospital (medical and geriatric) level care for up to 58 residents. On the day of the audit, there were 55 residents. Twenty residents were at rest home level of care and 35 were at hospital level. This included two respite (hospital), three long-term chronic conditions (LTCC) (one rest home, two hospital) and two DHB funded interim care (hospital). Six beds are rest home only and the remaining are dual purpose.</p> <p>A 2016 strategic plan is being implemented. The clinical manager reports that she meets with the owner regularly and that meetings include reviewing the strategic goals. Quality goals are also documented for the service. These goals link to the strategic plan and are regularly reviewed in staff meetings.</p> <p>The experienced clinical manager is a registered nurse who has been in her role for the past 16 years. She has maintained a minimum of eight hours relating to managing an aged care service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>A quality and risk management programme is being implemented. A document control system is in place but document reviews are behind schedule. Policies and procedures have not been updated to include reference to InterRAI for an aged care service. New policies or changes to policy are communicated to staff in staff meetings. Interviews with the clinical manager/RN and eight staff (three caregivers, three RNs, one activities coordinator, one cook) reflected their understanding of the quality and risk management systems that have been established.</p> <p>Quality data is collected for adverse events including falls and skin tears, pressure injuries (if any), and infections. This data is collated, trended and analysed and is regularly communicated to staff in staff meetings. A resident/family satisfaction survey was last completed in April 2016. The clinical manager conducts quarterly residents meetings. Families are invited to attend. These are improvements from the previous audit.</p> <p>Internal audits are completed as documented in the audit schedule. Corrective actions are not consistently completed when internal audit findings are identified. Quality initiatives for 2016 have included improving the presentation of food to residents, freeing up caregiver staff to assist with activities, and the development of medication management initiatives to reduce the number of medication errors. These quality initiatives have not been evaluated or signed off as completed.</p> <p>Falls prevention strategies include the use of sensor mats and implementing strategies for frequent fallers.</p> <p>A health and safety programme is in place that meets legislative requirements. The health and safety team of five staff including the clinical manager meets regularly. Health and safety policies have recently been reviewed (August</p>

		2016). Hazard identification forms and a hazard register reflect the regular monitoring of hazard controls. Staff education, which begins during their induction to the service, includes the topic of health and safety.
<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>Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required (link to finding 1.1.9.1). Incident/accident data is linked to the facilities quality and risk management programme (link to finding 1.2.3.8). Fifteen accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations have been undertaken if there is a suspected head injury.</p> <p>The clinical manager is aware of her responsibility to notify relevant authorities in relation to essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resources policies address recruitment, orientation and staff training and development. Five staff files randomly selected for review (three caregivers, two registered nurses) included evidence of the recruitment process including police vetting, signed employment contracts, completed orientation programmes, and annual performance appraisals. Missing was evidence of reference checking.</p> <p>The orientation programme provides new staff with relevant information for safe work practice and is developed specifically to worker type. Staff interviewed stated that new staff are adequately orientated to the service.</p> <p>There is an annual education and training schedule that is being implemented. This is an improvement from the previous audit. Education and training for the RNs are supported by the DHB. One RN has completed her InterRAI training with one day per week allocated to completing InterRAI assessments (link to finding 1.3.3.3). Medication competencies are up-to-date. Current annual practising certificates were sighted for the registered health professionals. There is a minimum of one staff member available 24/7 with a current first aid/CPR certificate.</p>
<p>Standard 1.2.8: Service Provider</p>	FA	<p>A staffing plan is documented for the service. The clinical manager and charge nurse are available five days a week (Monday – Friday). Additional staff RN cover is provided 24 hours a day, seven days a week with two RNs on</p>

<p>Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>the am and pm shifts and one RN on the night shift.</p> <p>RNs are supported by adequate numbers of caregivers. Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>Eight of ten medication charts reviewed demonstrated that the resident had been reviewed by the general practitioner within the last three months (two medication charts were for residents recently admitted to the facility). All medicines are dispensed to the facility by a contracted pharmacy. Unused medicines are returned to the dispensing pharmacy. The storage of medicine was secure. There was a system of medicine reconciliation in use for newly admitted residents. There were no residents self-administering medications at the time of audit. Medicines are administered by registered nurses who have been assessed annually as competent by other registered nurses. In the rest home, registered nurses and medication competent caregivers administer medication. Registered nurses have completed syringe driver training and there is a close liaison with the hospice for advice and support for palliative care residents. The hospice nurse was visiting during the audit and when interviewed spoke highly of the care that residents receive and the clinical competence of the registered nursing team.</p> <p>Medication fridge temperatures were being monitored daily and the temperature ranges were within accepted limits and actions taken if discrepancies were noted. This finding from the certification audit has been addressed. Medicines were not evidenced to be charted correctly around the prescribing of warfarin medication. Medication signing charts sampled evidenced transcribing of medications. The facility uses standing orders; however, these have not been reviewed by the GP in the required timeframe.</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</p>	<p>FA</p>	<p>The menu has been developed by the cook in consultation with the dietitian. The menu for the day is displayed on noticeboards in the hospital and rest home. Staff were aware of residents' food preferences and needs of those residents who could not indicate their own choices. For some residents that are not able to choose, the families are involved in choosing the meals for their liking. The cook interviewed was aware of all residents' food preferences and special requirements and these preferences were recorded on a noticeboard in the kitchen. The kitchen was well equipped. Food was being appropriately managed in line with food safety guidelines. Food was delivered to each resident area in a hot box then decanted into heated bain-maries, and then served by staff according to resident choice. Staff were observed to be assisting those residents who required help with their food and fluid intake at meal times.</p> <p>Additional nutritious snacks were available for all residents.</p>

delivery.		The cooks were qualified and the kitchen staff had attended food safety education.
Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	<p>Caregivers follow the care plans and report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral. Staff have access to sufficient medical supplies including dressings. Sufficient continence products are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described.</p> <p>Monitoring forms are in place for restraint use, behaviour management, fluid balance charts, turning charts and pain management.</p> <p>Wound documentation is available and includes assessments, management plans, progress and evaluations. However, the wound assessments were not evidenced to be consistently fully completed. This finding from the previous audit has not been addressed. In the rest home, there were two skin tears and one with a chronic wound currently being treated. There were nine hospital residents with wounds including two stage-one and two with stage-two pressure injuries; two skin tears and one laceration. The RNs have attended wound care training. Not all care plans included current interventions to meet the needs of residents; however care being provided was meeting the needs of the residents.</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.	FA	<p>The service employs an activities coordinator and an activities assistant to plan and coordinate the individual and group activities programme, which was offered in the rest home and hospital for five days per week. Care staff also participated in providing the individual and group activities programme. There is a large recreation room located in the hospital which is used for group activities. Residents were observed participating in an exercise programme and being entertained by a musician in the afternoon. Residents from the rest home were assisted to attend the exercise programme and entertainment session which were occurring in the hospital unit. Each resident had a written and implemented activities programme, which was not consistently evaluated monthly and reviewed each time their long-term plan of care was reviewed (link to 1.3.3.3). A weekly programme was displayed in large print in each area and staff were able to inform residents as to the programme and to direct them to attend the activity of their choice. A daily record of each resident's participation in group and individual activities was maintained. A wide range of activities were included in the programmes. The group programme included external outings. The facility has pets including a ewe and lamb which residents are able to see in the adjacent paddock.</p> <p>Residents and relatives interviewed spoke highly of the activities programme.</p>
Standard 1.3.8: Evaluation	FA	Registered nurses completed a review of all resident's initial care plans within three weeks of their admission. The senior charge nurse had a system in place which ensures that each resident was formally reviewed six monthly by

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>all members of the multidisciplinary team and a record of the review was documented. Families were contacted and invited to contribute their opinions and attend these reviews where possible. Following the review, the resident's long-term care plans were amended to reflect any changes (also link 1.3.6.1). Care plans were evidenced to be evaluated six monthly and the goals or interventions were amended to address any areas of non-achievement towards the goals.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location (expiry 15 December 2016).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed on the staff infection control board in the staff office. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the infection control committee meetings and clinical meetings. Trends are identified and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.</p> <p>There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>The restraint policy includes the definitions of restraint and enablers and comprehensive restraint procedures. The education and training programme includes regular in-service training on restraint minimisation. Interviews with the care staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required, for maintaining safety and independence and are requested voluntarily by the residents. At the time of the audit, the service had four hospital level residents using enablers and six hospital-level residents using restraints.</p>

minimised.		One file selected where an enabler (bedrails) was in use reflected evidence of an assessment for enabler use, written consent by the resident, and was linked to the resident's care plan.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Two hospital level residents' files were selected where bedrails were being used as a restraint. Both files contained an assessment that identified any potential risks related to the use of the restraint and described the desired outcome. All aspects of the criterion 2.2.2.1 were being met. This is an improvement from the previous audit.
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The use of restraint is linked to the resident's care plan, sighted in both residents' files where restraint (bedrails) were being used. Evidence was also sighted to verify that two hourly checks were documented on the restraint monitoring forms for both residents. These are improvements from the previous audit.

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.1.9.1 Consumers have a right to full and frank information and open disclosure from service providers.	PA Low	Accident/incident reports reviewed did not consistently reflect that families were kept informed. Three families interviewed (one rest home and two hospital) stated that they are kept informed when their family member’s health status changes or in the event of an accident/incident.	Five out of fifteen accident/incident reports, which included two pressure injuries, two skin tears and one bruise incident, did not indicate that families were informed.	Ensure that documentation on accident/incident forms reflects families being kept informed following an accident/incident.  90 days
Criterion 1.2.3.4 There is a document control system to manage	PA Low	A document control system has been established. Policies are scheduled for two yearly reviews unless changes occur with greater frequency. Selections of policies on the document review schedule are overdue for review.	Some policies are behind schedule for a two-yearly review (eg, pressure injury prevention and management, bladder care, blood accidents, bowel care). A	Ensure policies are reviewed as per the document review schedule. InterRAI

the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.			policy and procedure around the implementation of InterRAI has not been developed.	procedures are required.  90 days
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>i) The internal audit process is required to include corrective action plans when results are less than acceptable. There were a sample of internal audits completed that identified findings without associated corrective action plans.</p> <p>ii) When quality initiatives are developed, they should be evaluated and signed off when completed.</p>	<p>i) Internal audit results that identify findings do not consistently include corrective action plans.</p> <p>ii) Quality initiatives developed in 2016 around the activities programme and medication management have not been evaluated or signed off.</p>	<p>Corrective action plans are required where internal audit results reflect a need for improvement. Ensure quality activities are evaluated and signed off.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	Recruitment policy and procedures describes the appointment process. The clinical manager confirmed that interviews are conducted and reference checking is being completed but the clinical manager was unable to locate the file with documented evidence to verify the reference checking process.	Staff files reviewed confirmed evidence of reference checking in only one of five files. The clinical manager reported that reference checking is completed for all applicants prior to an appointment being made, but she was unable to locate the paperwork.	<p>Ensure that there is documented evidence to confirm reference checks are completed for new staff.</p> <p>90 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The signing sheets for regular and 'as required' medications corresponded with the instructions on the medication chart. However, transcribing of medications was noted on four of ten medication signing charts reviewed. 'As required' medications had 'indications for use' documented on the medication chart. Standing orders are in use but have not been reviewed within the required timeframes. The pharmacist completes a weekly stocktake of controlled drugs delivered with the RNs. Eight of ten medication charts reviewed evidenced prescribing that aligns with best practice.</p>	<p>(i) Two residents on warfarin did not have a signed warfarin medication order. A telephone verbal order from the GP practice based on the INR result is received by the RN on duty. Verbal orders received were not documented on the medication chart but were documented on a 'Warfarin INR chart'. The chart was evidenced to be signed by the RN but a GP signature and registration number was not included in the order.</p> <p>(ii) Standing orders have not been reviewed annually. Last date of review occurred in 2014.</p> <p>(iii) Transcribing of medication orders was noted on four medication signing charts (three hospital and one rest home).</p>	<p>(i) Ensure that all medications orders are signed and dated by a GP.</p> <p>(ii) Ensure that Standing Orders are reviewed as per MOH medication guidelines.</p> <p>(iii) Transcribing of medications on medication signing charts is to cease.</p> <p>30 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 Moderate</p>	<p>InterRAI initial assessments and assessment summaries were evident in printed format in two of three permanent resident files reviewed. Two InterRAI assessments had been completed outside of the required timeframe. Other facility clinical risk assessment tools provide further means of assessing care needs and are an add-on to the InterRAI assessment. Progress notes documentation by caregivers was regular and comprehensive. Follow-up of any caregivers concerns with regards to resident's health condition were documented by a registered nurse. Care plans were not consistently updated when there was a change to residents' needs (link 1.3.6.1). Three of three activity plans for permanent residents were not evidenced to be reviewed within</p>	<p>(i) Two of three resident files reviewed where an InterRAI assessment was contractually required, one had not been completed and two had been completed outside of the required timeframes.</p> <p>(ii) Three permanent resident files reviewed did not evidence that activity plan evaluations had been completed monthly and six monthly as per policy.</p>	<p>(i)-(ii) Ensure that InterRAI assessments are completed within the required timeframes and/or when there is a change in the resident's condition and that activity plans are reviewed within the required</p>

		the required timeframes.		timeframes.  60 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA</p> <p>Moderate</p>	<p>Three of five care plans reviewed contained appropriate interventions to meet the residents' identified needs. Examples were sighted where short-term care plans were in place and had been reviewed by the registered nurse</p> <p>Wound assessment, monitoring and wound management plans are in place for eleven of twelve wounds. Not all wound care documentation was fully completed or updated.</p>	<p>(i) The care plans for two residents with unintentional weight loss recorded (one resident with 3kg weight loss in three months and one resident with 7kg weight loss over six months) had not been updated to reflect the nutritional and dietary interventions that were observed currently being implemented.</p> <p>(ii) The care plan of one hospital resident with a stage-2 pressure injury had not been updated to reflect the pressure injury and appropriate pressure relieving management interventions that were observed implemented, for example, alternating air wave mattress sighted on bed and two hourly changes of position, which were documented on turning charts sighted.</p> <p>(iii) Wound care documentation was incomplete for three of nine wounds in the hospital unit. Three assessments did not document the classification of wound and timeframes for review. One hospital resident with a recent wound did not have a wound assessment or</p>	<p>(i-ii) Ensure that care plans are updated when there is a change in resident need.</p> <p>(iii) Ensure that wound assessment and management plans are fully documented and followed and that all wounds have interventions documented in either a short-term care plan with regular documentation reviews, or in a long-term care plan.</p> <p>60 days</p>

			short-term care plan in place to document the interventions required. Interviews identified staff were managing the wounds.	
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.