# The Napier District Masonic Trust - Taradale Masonic Residential Home & Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** The Napier District Masonic Trust

**Premises audited:** Taradale Masonic Residential Home & Hospital

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

**Dates of audit:** Start date: 24 January 2017 End date: 25 January 2017

**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:** 64

# Executive summary of the audit

## Introduction

This section contains a summary of the auditors’ findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

* consumer rights
* organisational management
* continuum of service delivery (the provision of services)
* safe and appropriate environment
* restraint minimisation and safe practice
* infection prevention and control.

As well as auditors’ written summary, indicators are included that highlight the provider’s attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

**Key to the indicators**

| **Indicator** | **Description** | **Definition** |
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|  | Includes commendable elements above the required levels of performance | All standards applicable to this service fully attained with some standards exceeded |
|  | No short falls | Standards applicable to this service fully attained  |
|  | Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity | Some standards applicable to this service partially attained and of low risk |
|  | A number of shortfalls that require specific action to address | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk |
|  | Major shortfalls, significant action is needed to achieve the required levels of performance | Some standards applicable to this service unattained and of moderate or high risk |

## General overview of the audit

Taradale Masonic Residential Home & Hospital is part of the wider Napier District Masonic Trust. Taradale provides rest home and hospital level of care for up to 74 residents. At the time of audit there were 64 residents. The strengths of the service include the staff education programme and the activities programme that the residents report high satisfaction with.

This unannounced surveillance audit was conducted against the relevant Health and Disability Service Standards and the service’s contract with the district health board. The audit processes included the sampling of policies and procedures, sampling of resident and staff files, observations and interviews with residents, families, management and staff.

There were no previous areas of non-conformance that were required to be followed up from the previous certification audit.

There are two new areas for improvement from this audit related to the monitoring of the medication fridge temperature and ensuring the minimum staffing levels are maintained at all times on the night shift.

## Consumer rights

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| Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs. |  | Standards applicable to this service fully attained. |

There are appropriate systems to communicate effectively with the residents and family/whanau. Open disclosure is evidenced in the sampling of adverse events.

There is an easy to understand and access complaints management system. The complaints register records all complaints, dates and actions taken.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

There is a board of trustees that provides the overall governance and strategic directions. The goals, values, mission and philosophy of the trust are clearly documented. The organisational performance is reviewed through monthly board meetings.

The service is managed by a suitably qualified and experienced person with a background in quality management. The facility manager is responsible for the overall management of the service and reports monthly to the board. The manager is supported by a clinical manager, who has the responsibility for the provision of the direct resident care.

There is an established quality and risk management system that is implemented and understood by the staff. There are internal auditing processes that monitor all aspects of service delivery. The results of internal audits, adverse events and other quality data is collected, reviewed and evaluated. Where areas for improvement are identified, corrective action plans are implemented. The corrective actions implemented are reviewed to ensure the required improvements have been effective.

There are human resource management processes implemented for the selection, recruitment and orientation of new staff members. There is an ongoing in-service education programme that meets the requirements of the standards and the specific needs of the service. There are adequate staffing numbers and skill mix to meet the requirement of service delivery to the rest home and hospital level of care residents if there are no call outs to the retirement village at night.

## Continuum of service delivery

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

Residents receive appropriate services that meet their desired goals/outcomes. Residents are admitted with the use of standardised risk assessment tools. Long and short term care plans are developed and evaluated in a timely manner. Interventions are sufficiently detailed to address the desired goals/outcomes. Short term care plans are developed when acute conditions are identified and resolutions are documented.

Planned activities are appropriate to the needs, age and culture of the residents who reported that activities provided are enjoyable and meaningful to them.

The processes for medication administration and charting meet the required regulations and guidelines.

Food services meet the food safety guidelines and legislation. The individual food, fluids and nutritional needs of the residents are met. Sampled resident records evidenced stable weights and interventions are in place when weight changes are identified.

## Safe and appropriate environment

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

The current building warrant of fitness is displayed. There are temporary changes to the evacuation scheme during the renovation and construction of four of the current rest home rooms. There are appropriate systems in place for resident, visitor and staff safety during the construction process.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Policies and procedures identify the safe use of restraints and enablers. When enablers are used, these are voluntary and the least restrictive option to maintain independence, comfort and safety. There is restraint and enabler use at the time of audit. Risk management plans are in place to prevent restraint-related injuries.

## Infection prevention and control

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

Infection prevention and control policies and procedures are in place to maintain a low infection rate in the facility. The infection control coordinator is new to the role and is currently assisted by the facility manager. Infection rates are collated and analysed monthly. The type of surveillance is appropriate to the size and complexity of the service. The infection rate data are reported to the board and quality team.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 44 | 0 | 2 | 0 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk****(UA Negligible)** | **Unattained Low Risk****(UA Low)** | **Unattained Moderate Risk****(UA Moderate)** | **Unattained High Risk****(UA High)** | **Unattained Critical Risk****(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | Complaints forms are available and accessible throughout the facility. The complaints policy has times frames for complaints management that comply with Right 10 of the Health and Disability Commissioner Code of Health and Disability Services Consumers’ Rights (the Code). The complaints policy is cross referenced to the information on policies on the Code. The residents and families reported and easy to use and responsive system if they wished to make a complaint. The complaints register sighted contains a summary of all complaints, dates and actions taken. The register records that all complaints received in 2016 were resolved to the satisfaction of the complainant.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | The residents and families report that they receive open and honest communication from the staff. The family report that they are informed of any incident or accidents that have occurred with their relatives. Open disclosure is confirmed on the adverse event forms sampled.As required the service can access interpreters. All resident can effectively communicate in English. Communication strategies for residents are documented in the care plans sampled.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The service that is part of the wider Napier District Masonic Trust (NDMT) and located within a retirement living complex. The service provides rest home and hospital level of care. The rest home and hospital level of care residents are in separated wings. There are also six independent living units that have been assessed as being capable of providing rest home level of care. No rest home level of care is currently provided to the people living in the independent living units. There were 34 rest home and 28 hospital level of care residents (which includes one resident under the age of 65) at the time of audit. The board of trustees provides the governance and strategic direction for the service. The trusts mission, vision and policies are documented in the annual strategic plan. The progress towards meeting the identified goals is reviewed at the monthly board meetings. The service is managed by a suitably qualified and experienced facility manager, who is responsible for the overall operational and quality management of the aged care serve and retirement complex. The facility manager has been employed by NDMT in the role for coming up over six years and has been the facility manager since August 2012. The facility manager is supported by a clinical manager and a clinical coordinator for the clinical management of the service. The management team each have attended over eight hours’ education in the past year related to the management of an aged care service. There is a general manager who is responsible for the village/retirement service. The facility manager and clinical manager both provide monthly reports to the trust and the general manager. The residents and families report satisfaction with the care and services provided at the service.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The quality and risk plan was updated and reviewed for the 2016-2017 period. There are goals and objectives for all aspects of service delivery. Each of the quality goals include a guide for implementation, action plan and time frames for delivering the improvements. The service used a plan, do act, check quality improvement approach. The staff meetings provide a forum for discussing quality and risk issues, as confirmed in the review of meeting minutes and interviews with staff. The staff interviewed demonstrated knowledge of the quality and risk management systems. The results of the quality systems, the quality data and internal audits are displayed in the staff rooms. The policies and procedures are referenced to legislation and current accepted good practice. The policies are reviewed on a two-year cycle, or sooner if there are any best practice or legislative changes. There are organisational policies that apply across the wider trust and policies and procedures that are specific to the Taradale home and hospital (such as infection control, kitchen, maintenance, laundry and fire and emergency). All the policies sampled are version controlled and current. Staff only have access to the most recent version of policies and procedures. The obsolete documents are archived. There is a system in place to enable the retrieval of documents as needed. Archiving and destruction of records is conducted in line with legislation. The internal auditing system (including safety inspection and satisfaction surveys) is used to monitor the quality and risk management systems. The internal audit schedule covers all aspects of service delivery (including pressure injury management). The internal audits sampled record the aim, method, frequency, audit outcomes, frequency, comments and recommendations. If shortfalls are identified, corrective action/quality improvement plans are commenced. The corrective action plans sighted record the area for improvement, the improvement plan, who is responsible, time frames for implementation and measurable improvement indicators to review if actions implemented have been effective. The quality data is reviewed and evaluated at the quality meetings. The reports to the board include a summary of the internal audits and the quality and risk summaries. The business plan includes risk analysis and strengths, weakness, opportunities and threats analysis. This records organisational risks, actions implemented and monitoring requirements to reduce/minimise the occurrence or impact of the risk. The service also has a hazard register that identifies the hazards in the facility and delivery of services. This includes risk minimisation strategies to address the risks associated with service provision.  |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | The management team and staff understand their responsibilities related to mandatory reporting and essential notifications. This includes responsibilities related to reporting of stage 3 and above pressure injuries. The number of incidents are collated on a monthly basis. Samples of incident/accident forms and the trended data were reviewed at the quality meetings. Any trends identified are notified and information fed back to the board, at staff meetings and displayed on the staff notice board. The service identifies strategies put in place in response to incidents and accidents and these were documented on the actual individual incident forms and on the resident`s care plan as required.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | FA | All staff and contractors who require an annual practising certificate (APC) have these validated at employment and annually. A register is maintained of when APC and competency assessments are due. Copies of APCs were sighted for all staff who require them. Staff files provided evidence that appropriate processes are implemented for the recruitment, employment and orientation of new staff. There are at least annual performance reviews for the staff. The orientation, induction and ongoing education programme meets contractual requirements and the specific needs of the rest home and hospital level of care residents. Mandatory training to meet contractual obligations is two yearly, or more frequently for such topics as infection control and restraint minimisation and safe practice. The education schedule was reviewed for 2016 and the upcoming 2017 year has content and variety and meets all obligations of the provider’s residential care contract with the district health board.The service has an education coordinator, the services supports the health care assistants and support staff to gain level three and national qualifications in aged care, diversional therapy and support services. There are in-service programmes and mandatory training days for the care and support staff and a separate programme for the nursing staff. Each month there is a focus of the education programme (such as pressure injury prevention, nutrition, oral care). Where training or shortfalls in staff performance or achievement of goals/outcomes are identified, there is additional training implemented to assist staff achieve their desired outcomes throughout the year. The staff report that the education programme is of a high standards and provide relevant topics to assist them improve their skills and knowledge.  |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Low | The staffing levels and skill mixes meet the minimum requirements for the rest home and hospital level of care residents (if there are no call outs). The night time call out to the retirement complex is covered by a caregiver in the rest home, this would leave the rest home staffing level under the minimum numbers (refer to 1.2.8.1).  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | A medicine management system is not consistently implemented to ensure safe storage of medicines to the residents. All other aspects of medication management are compliant with current legislation and safe practice guidelines. Allergies and indications are documented as well as necessary identifiers. Medication records are reviewed every three months and there was no evidence of transcribing of medications. Weekly and six monthly controlled drugs stocktakes are conducted. The controlled drugs register was correct and current. A system is in place in returning expired or unwanted medications to the pharmacy. Improvement is required in relation to monitoring and recording medication fridge temperature.The staff administering the lunch time medications complied with the medicine administration policies and procedures. Current medication competencies are evidenced in the staff files.There is one resident who self-administers medications. System are in place to ensure safe storage and compliance in relation to self-administration of medications. Self-medication evaluations are completed monthly. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Food service policies and procedures include principle of food safety, ordering, storage, cooking, reheating and food handling. A system is in place when receiving and utilising kitchen supplies. Staff who work in the kitchen have current food handling certificates. The kitchen staff use safe food handling practices when preparing meals. A kitchen cleaning schedule is implemented.Residents are provided with meals that meet their food, fluids and nutritional needs. Dietary requirement forms are completed by RNs on admission and a copy is provided to the kitchen. Modified foods are also provided by the service. The meals are well-presented and the residents confirmed that they are provided with an alternative meal as per request. Residents have stable weights and residents with weight changes are provided with food supplements or fortified foods. All meals are prepared and cooked onsite. Cooked meals are plated from the kitchen to the main dining area while meals for the residents in other units are plated from a bain marie. Fridge and food temperatures are recorded daily. There is evidence that the current menu is reviewed every two years by a dietitian.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Long term care plans are developed by a designated registered nurse who is one of the interRAI assessors. Interventions in both long and short term care plans are sufficiently detailed to address the desired goals/outcomes. Documented interventions are practical and staff reported that it is easy to follow.Monitoring forms are in use as applicable, such as weight, observations, wounds and behaviour.Wound assessment, monitoring and wound management plans are in place for residents that require them. The RNs have access to specialist nursing services like wound and mental health services. |
| Standard 1.3.7: Planned ActivitiesWhere 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 | Activities provided are appropriate to the needs, age and culture of the residents. Activities are developed to be physically and mentally stimulating and appropriate to the resident’s capability (eg rest home or hospital level of care). There are group and individual activities provided. The two activities coordinators develop the activity programme and plans using the resident’s profile gathered during the interview with the resident and their families. Weekly activities are posted in all corridors as well as dining areas. Activity plans are documented and reflect the resident’s preferred activities and past interests. A participation log is maintained and residents with changes in participation are referred to the RNs for further assessment and management. Interviewed residents and their families reported satisfaction with activities provided by the service. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Long and short term care plans are evaluated in a comprehensive and timely manner. Evaluations include the residents’ degree of achievement towards meeting the desired goals/outcomes. Resident’s response to the treatment regime in the short term care plan is documented. Changes in the interventions in both long and short term care are evidenced when goals are not satisfactory. Resolutions are documented in the short term care plans. |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The current building warrant of fitness is displayed. There is current construction and renovation building works to four existing rooms in the rest home section. The contractor has installed fencing to isolate the construction area from the rest of the service. The required safety signage is in place. All the building, plant and equipment comply with legislation requirements during the construction period. The remainder of the facility has an ongoing maintenance programme, electrical safety procedures and equipment calibration. The corridors have hand rails and intact flooring surface to promote safe mobility. During the construction one of the outside areas/internal courtyards is not able to be accessed, there are alternative outside areas that the residents can access during the construction period. |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | There is a temporary change to the evacuation scheme during the conduction period. One fire zone has required one of the fire egress routes to be blocked to isolate the construction site. A temporary evacuation plan, change in evacuation signage and exits are in place. The fire service contractors have been informed of the changes, with an interim fire evacuation drill scheduled for 25 January 2016, which will include the temporary changes in zone 5. The previous evacuation drill was conducted in September 2016. The evacuation scheme was approved by the fire service in 2013. The staff file and training records evidence that staff review essential, emergency and security systems training as part of the orientation and ongoing education programme. In the event of an emergency the service has access to at least three days of food and water. The service has access to a generator for power in the event of an emergency. There is a call bell system fitted throughout the building, which remains operational during the construction. The night time security includes an automated alarm system on external access points.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | Surveillance activities are appropriate to the size and complexity of the setting. Surveillance is carried out in accordance to the agreed objectives and methods in the infection control programme. One of the RN is the newly-appointed infection control coordinator and is supported by the facility manager. Infection rates data are monitored and analysed by the infection control coordinator. Interventions to reduce the infection rates are discussed with the staff during staff meetings and daily handovers. Monthly infection data are reported to the board and quality team. The quality data sampled (and interviews with the clinical and facility managers) record that there was an outbreak of nausea and vomiting sine the last certification audit. The analysis records that transmission based precautions were implemented to respond to the outbreak. There have been no further outbreaks since 2015.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The service demonstrated that the use of restraint is utilised as a last resort in providing safety and comfort to the residents. There were 17 residents using 19 restraints and one resident using an enabler. The restraint register is current and updated. Risk management plans are in place to minimise restraint-related injuries for residents on restraints. Restraint minimisation policies and procedures are in place, and include definitions, processes and the use of restraints and enablers.Staff demonstrated good knowledge regarding restraint and enablers. The clinical coordinator is the designated restraint coordinator for the service.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.8.1There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Low | Staffing levels for the aged care facility are based on contractual requirements. The care staff numbers for the rest home and hospital exceeded the minimum requirements during the morning and afternoon shifts. The rostered night staffing levels comply with the contractual requirements (one RN and three caregivers across the rest home/hospital). During the morning and afternoon shifts there are additional staff that provide coverage the retirement living complex units. At night a caregiver in the rest home is required to respond to call outs in the retirement complex. When this occurs this would leave the rest home short staff (one caregiver). A review of the previous month’s rosters records that there were no call outs to people living in the retirement complex. The general manager of the trust reported that they will amend their policy immediately to ensure that minimum staffing numbers are maintained at all times in the rest home/hospital. As there have been no recorded callouts in the past month and an action plan was verbalised by the general manager at the time of audit, the risk level has been assessed as low. A review of four weeks of rosters for the rest home and hospital wings are staffed to ensure there is a skill mix and sufficient numbers of staff to meet residents' needs. All sick leave and annual leave is shown and replacement staff noted. There are sufficient numbers of laundry, housekeeping, activities, support, and maintenance and administration staff. Four RNs have completed their required interRAI training and demonstrated knowledge on the use of this tool to assess resident’s needs to inform the care planning process. | The minimum staffing levels are not maintained on night shift if a caregiver is required to attend a callout to the retirement living complex/units.  | Ensure minimum staffing levels are maintained at all times. 90 days |
| Criterion 1.3.12.1A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | The medication fridge temperature was last recorded in August 2016. Medication fridge temperature were previously monitored by weekly the night registered nurse. These temperatures are within the accepted readings. A system was implemented on the day of the audit to ensure that fridge temperatures are monitored and recorded weekly.  | The medication fridge temperature is not consistently recorded.  | Provide evidence that there is at least weekly recording of the medication fridge temperature.180 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| No data to display |

End of the report.