

# Maniototo Health Services Limited - Maniototo Health Service

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## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services 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:** Maniototo Health Services Limited

**Premises audited:** Maniototo Health Services

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

**Dates of audit:** Start date: 9 May 2017 End date: 10 May 2017

**Proposed changes to current services (if any):** A partial provisional audit is required to determine whether increasing the number of dual purpose beds by four as per HealthCERT letter dated 10 May 2017, meets the HDSS and contractual requirements. The total of beds will increase from 31 to 35.

**Total beds occupied across all premises included in the audit on the first day of the audit: 27**

# 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

Maniototo Health Services Limited can provide care for up to 31 residents/patients. A certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board. Occupancy on the day of the audit was 27. The service provides medical services for patients with acute conditions and residential long-term hospital and rest home level care.

The service currently has 15 dual purpose beds. A partial provisional audit was also undertaken to establish the level of preparedness of Maniototo Health Services Limited to provide additional beds for hospital level of care by adding a further four dual purpose beds. Maniototo Health Services Limited has an inpatient unit for acute care, a wing for residents requiring hospital level care and a separate building adjacent to the hospital for residents requiring rest home level care.

The audit process included the review of policies, procedures and resident and staff files, and observations and interviews with patients, family, management, staff, a general practitioner and a board member. The general manager provides strategic and operational management with support from the clinical nurse manager. A quality and risk management programme is documented. Staffing levels were reviewed for anticipated workloads and acuity.

Improvements are required to the following: complaints management, adverse reporting, general practitioner reviews, care planning and medication.

## 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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights, the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible in information packs and displayed within the service. Residents/patients and family members confirmed their rights are met, staff are respectful of their needs and communication is appropriate.

Residents/patients, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

## 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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The service has a documented quality and risk management system. The general manager is qualified and experienced in management systems and processes. The clinical nurse manager and assistant manager in older person's health are qualified for their roles. Policies are reviewed and quality and risk performance is reported through regular meetings.

The facility has a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed and are current. Quality and risk performance is reported through meetings and monitored by the organisation's management team through business reports. Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators. Resident/patient information is identifiable, accurately recorded, current, confidential, accessible when required and securely stored.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development. Staff, residents/patients and family confirmed that staffing levels are adequate and residents/patients and relatives have access to staff when needed. Staff are allocated to support residents/patients as per their level of care and individual needs. Staffing levels are appropriate for the service to be able to provide services to four more hospital level residents/patients (dual purpose beds), should this be needed.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry and assessment processes for acute medical and residential care services are recorded and implemented. Residents/patients clinical records evidence assessments, care planning and care evaluations are undertaken in a timely manner. Members of the multidisciplinary team document residents/patients care and treatment. Residents/patients and family have input into assessments, care planning and evaluations of progress.

Daily medical rounds provide a forum for planning for the acute medical patients for discharge or referral to other services. There is timely access to allied health services. An activities programme is provided for rest home and hospital residents. Medicine management policies are in place. Staff who administer medications have current medication competencies. There were no residents self-administering medicines at the facility on audit days.

The food service is provided by an external contractor. The menu has been reviewed by a dietitian. The kitchen staff have completed food safety training.

## 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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All building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents/patients. A preventative and reactive maintenance programme includes equipment and electrical checks.

Residents/patients are provided with accessible and safe external areas. Residents/patients' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place and fire drills are completed every six months. Call bells are available to all residents/patients and are monitored monthly. The environment meets the requirements to incorporate four additional dual purpose beds.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The approval process for enabler use is activated when a patient or resident voluntarily requests an enabler to assist them to maintain independence and/or safety. There were four residents using restraints and no enablers required on audit days. Staff education in restraint, de-escalation and challenging behaviour has been provided. Policies and procedures on restraint and enabler use are current.

## 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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There is an established infection prevention and control programme, led by experienced practitioners. Processes are in place to minimise infections. Staff are educated and there are educational resources for patients and residents. Surveillance data is collated, analysed and reported.

## 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	45	0	4	1	0	0
<b>Criteria</b>	0	96	0	4	1	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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents and patients stated that they receive services that meet their needs and they receive information in relation to their needs. Staff receive education on the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme.</p> <p>All staff have had training on the Code during the previous 12 months. Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; giving residents choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents and patients on the days of the audit.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice</p>	FA	<p>There is an informed consent policy and procedure that directs staff in obtaining informed consent. Staff ensure that all residents/patients are aware of treatment and interventions planned, and the resident/patients</p>

<p>are provided with the information they need to make informed choices and give informed consent.</p>		<p>and/or significant others are included in the planning of that care. Resident/patients files evidenced informed consent is obtained. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>Service information pack includes information regarding informed consent. The GM, CNM and assisting manager for older person's health discuss informed consent processes with residents/patients and their families during the admission process. The informed consent policy and procedure includes guidelines for consent for resuscitation/advance directives. Resuscitation orders are completed for residents/patients when applicable.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information relating to advocacy services is available at the entrance to the facility and in information packs provided to residents/patients and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training regarding advocacy services was provided earlier in 2017.</p> <p>The health and disability advocate visits the service, as confirmed by the management team. Family and residents/patients confirmed that the service provides opportunities for the family/EPOA to be involved in decisions and they state that they have been informed about advocacy services.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy and residents/patients may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome.</p> <p>Residents in the rest home are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrated that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood,</p>	<p>PA Low</p>	<p>Maniototo Health Services Limited's complaints policy and procedure is in line with the Code for written complaints and include periods for responding to a complaint. Complaint forms are available at the</p>

<p>respected, and upheld.</p>		<p>entrance. A complaints register is in place and the register includes: the date the written complaint is received; the source of the written complaint; a description of the written complaint; and the date the written complaint is resolved. Evidence relating to each written complaint is held in the complaints folder and register. Written complaints reviewed indicated complaints are investigated promptly and issues are resolved in a timely manner. Staff, residents/patients and family confirmed they knew the complaints process.</p> <p>There is no documented process to manage verbal complaints. Verbal complaints are not consistently recorded and evidenced in the complaints register. This is a requirement for improvement.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.</p>	<p>FA</p>	<p>The general manager (GM), the clinical nurse manager (CNM) and the assistant manager for older person's health, discuss the Code with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings.</p> <p>Patient, resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private where appropriate. The posters displaying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service ensures that each resident/patient has the right to privacy and dignity. The service has a philosophy that promotes dignity, respect and quality of life.</p> <p>The residents' own personal belongings are used to decorate their room in the hospital and rest home.</p> <p>A policy is available for staff to assist them in managing resident/patients practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for residents and patients.</p> <p>Staff confirmed that they knock on the door and identify themselves verbally before entering the room. This was observed on the days of the</p>

		<p>audit. Residents/patients and families confirmed that residents/patients' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports or on the incidents/accident forms reviewed in residents' files.</p> <p>Residents, staff, family and the general practitioner confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident/patients files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The organisation has adopted the Southern Region Māori Health Plan which guides the organisation. A subcommittee of the board has been appointed to develop a local view. There are currently no residents/patients that identify as Māori.</p> <p>Patient documentation identified ethnicity and identified any cultural needs, including identification of the needs of family/whānau. All patients interviewed indicated their cultural needs were recognised and respected.</p> <p>Staff interviewed demonstrated an understanding of the links in place with local Māori rūnanga, kaumātua, supports and services. Staff described encouraging family/whānau to be involved as much as possible.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>The service has a philosophy in place to treat people from all cultures, which encompasses residents from all cultures including Pacific people, with respect and dignity. This was confirmed in staff interviews. Staff demonstrated cultural awareness during the audit.</p> <p>Staff and resident/patient interviews confirmed there are choices for residents/patients regarding their care and services. Residents/patients and family are involved in the assessment and the care planning processes. Information gathered during assessment includes patients' and residents' cultural values and beliefs. The initial care plan, the long-</p>

		<p>term care plan and interRAI assessment for the residents in the hospital and rest home is based on this information.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. Residents/patients in the service did not require interpreting services on audit days.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Maniototo Health Services Limited has policies in place, which included providing services reflecting the Code, without discrimination, stigma or exploitation.</p> <p>All staff interviewed are aware of appropriate professional boundaries and can demonstrate knowledge to discuss strategies aimed at reducing discrimination. All residents/patients interviewed indicated staff were non-judgemental, demonstrate good understanding of the Code and provide services free from discrimination.</p> <p>Staff interviewed stated education in discrimination is included in the Code of Rights training offered monthly and is a mandatory component of annual staff training. Interviews with staff confirmed their understanding of professional boundaries, ethics and roles and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service implements policies to guide practice. The policies align with the Health and Disability Services Standards.</p> <p>The organisation's quality framework includes their internal audit programme. Benchmarking occurs. There is a training programme for all staff. Managers are encouraged to complete management training.</p> <p>Residents/patients and families expressed a high level of satisfaction with the care delivered.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/EPOA of any accident/incident that occurs.</p> <p>Procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident/patient has an incident/accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms. Family contact is</p>

		<p>recorded in residents'/patients' files. Family confirmed that they are invited to the care planning meetings for their family member and can attend the residents' meetings. Families confirmed they are well informed.</p> <p>Residents in the rest home sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. The admission agreements reviewed were signed on the day of admission.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The board provides a governance role with trustees who meet monthly. The service has a clear mission and values documented. The board works with the management team and staff to provide strategic direction. Monthly reports from the general manager (GM) to the board ensure the board is being informed of operational matters. The GM has accountant and management experience and has been in the role for more than eight years.</p> <p>There is a strategic/business plan that is developed by the board and the GM. The quality and risk plan is a rolling plan. There is a quarterly review process for management where the risk/strategy/improvement plans are updated.</p> <p>Maniototo Health Services Limited has a management team that includes the GM, the CNM and the assistant manager for older person's health. There is medical leadership from the general practitioner who is on site and on call during the week. There is a locum when the general practitioner is on leave to provide medical leadership. Primary Response in Medical Emergencies (PRIME) nurses are also available to provide primary response in a medical emergency.</p> <p>There are 31 beds, 16 in the rest home and 15 dual purpose beds for hospital (long-term care) and acute inpatient care. Occupancy on the day of the audit was 27 patients/residents. Of the twenty-seven patients/residents there were three acute patients, nine long-term residents and fifteen rest home residents.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures</p>	FA	<p>The CNM has the delegated position of second in charge with the role defined as providing operational management and leadership in the absence of the GM. The CNM has experience in management and</p>

<p>the provision of timely, appropriate, and safe services to consumers.</p>		<p>nursing roles and relevant qualifications including a current practicing certificate. The assistant manager in older person's health is able to provide support to the GM when the CNM is absent.</p>
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b> The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Maniototo Health Services Limited uses the quality and risk management framework to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required. Service policies are current, linked to the Health and Disability Sector Standards, applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hardcopy. New and revised policies are presented to staff to read and sign to evidence that they have understood the new/revised policy.</p> <p>Service delivery is monitored through complaints management; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented.</p> <p>Monthly staff meeting minutes including quality improvement, health and safety, and infection control. The minutes also evidence communication with staff around all aspects of quality improvement and risk management. There are resident meetings that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. Family are invited to come to the resident meetings. The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated.</p> <p>A survey for family and residents/patients was completed in 2017 and reflects the satisfaction of the residents/patients and family.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b> All adverse, unplanned, or untoward events are systematically</p>	<p>PA Low</p>	<p>The management team are aware of situations in which the service would need to report and notify statutory authorities, including, police attending the facility; unexpected deaths; sentinel events; notification of</p>

<p>recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>a pressure injury; infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board would be notified of any sentinel event.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand the adverse event reporting process and were able to describe the importance of recording near misses. There is a requirement for improvement relating to neurological observations after unobserved falls and staff designations on incident/accident records not being consistently recorded.</p> <p>Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</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>	<p>FA</p>	<p>The registered nurses hold current annual practising certificates along with other health practitioners in the service. Staff files include appointment documentation including signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all staff have an annual appraisal.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistants until they demonstrate competency on a number of tasks including personal cares. Health care assistants confirmed their role in supporting and budding new staff. A new staff member interviewed confirmed they had a comprehensive orientation programme.</p> <p>Annual competencies are completed by clinical staff and evidence of completion of competencies is kept on staff files. The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for internal training provided with some registered nurses and health care assistants attending.</p> <p>Education and training hours are at least eight hours a year for each staff member. Three of the registered nurses have interRAI training and staff have completed training around pressure injuries in 2017.</p> <p>There is a draft staff escalation plan in place for implementation, should the four dual purpose beds be used for hospital level of care. This plan</p>

		has been presented to staff for consultation.
<p><b>Standard 1.2.8: Service Provider Availability</b></p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>The staffing policy is the foundation for workforce planning. Staffing levels are reviewed for anticipated workloads, patient numbers and appropriate skill mix or as required due to changes in levels of care. Rosters sighted reflected staffing levels to meet resident acuity and bed occupancy.</p> <p>There are 53 staff, including the management team, clinical staff, a diversional therapist, and household staff. There is always a registered nurse on each shift. The GM and CNM are on call after hours. Residents/patients and families confirmed staffing is adequate to meet the residents'/patients' needs.</p> <p>New staff are being employed are expected to work across both facilities, the existing staff tend to work specifically in either rest home or hospital. The rest home has a designated RN on three days a week, the rest of the days there is oversight from the RNs on duty at the hospital.</p>
<p><b>Standard 1.2.9: Consumer Information Management Systems</b></p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents/patients and track records. This includes information gathered on admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff described the procedures for maintaining confidentiality of resident/patient records and care.</p>
<p><b>Standard 1.3.1: Entry To Services</b></p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Entry and assessment processes for acute medical and residential care services are recorded and implemented. Maniototo Health Services Limited provide emergency care for patients referred by a general practitioner (GP) but does not provide a regular or routine emergency department service.</p> <p>The patients admitted for acute medical services are provided with a pamphlet containing information about the medical inpatient services. The rest home and hospital residents sign an admission agreement that provides information about the services provided under the district health board (DHB) contract. An information booklet is also provided to residents and family, that is specific to residential care services.</p>

		The acute medical patients, long-term residents and their families confirmed in interviews the admission process was completed by staff in a timely manner and all relevant admission information was provided.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The medical patients' discharge plans ensure the required support is available at the time of the patients' discharges. The patients and family are informed and involved in discussions through the ward rounds.  There are documented protocols on transfers to and from the hospital. Ambulance or other forms of emergency transport may be required to transfer the patient/resident. Effective communication with the use of a transfer tool ensures a planned and coordinated transfers occur.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Moderate	The medication management system is implemented to ensure that residents/patients receive medicines in a secure and timely manner. Medications are stored in a safe and secure way. The service uses pharmacy pre-packed medication for residential care residents and these are checked by the RNs on delivery to the facility.  Records of temperatures for the medicine fridge have readings documenting temperatures within the recommended range. Medication administration observed at audit complied with safe administration practices.  An annual medication competency is completed for all staff administering medication as confirmed by staff and management interviews and staff files.  The drug register is current and correct. Weekly and six-monthly stocktakes are conducted.  There were no residents/patients self-administering medication at the time of the audit. There is evidence of inconsistencies in the completion of medication charts.  The proposed increase in dual purpose beds will not have an impact of the way the medicine management system is implemented.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are	FA	The food service is provided by an external food service company who provide a full meal catering service. The food is cooked off site and delivered to the facility. The menu is reviewed by a dietitian. It is a four

<p>met where this service is a component of service delivery.</p>		<p>week menu with summer and winter rotation. There is a documented, current food control plan. Special nutritional needs of patients and residents are able to be met.</p> <p>A dietary assessment is undertaken for each patient/residents on admission. The personal food preferences, special diets and modified nutritional requirements are communicated to the external food service company and to the kitchen staff and accommodated in the daily meal plan. Interview with the kitchen staff confirmed processes of food delivery, storage, food preparation and serving of food. Patient and resident interviews confirmed satisfaction with the food services.</p> <p>Kitchen staff have been provided with basic food handling training by the external provider in 2016.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>The proposed increase in dual purpose beds will not have an impact of the way the food services are provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>Acute medical patients are assessed upon referral by the GP. When the need for additional services is identified, arrangements are made to transfer patients to the appropriate service. Patients and referrers are informed of decisions when the patient has been referred/transferred following an assessment. The GP consults with tertiary hospital medical staff regarding the patient's referral to the service or direct referral to another service. This was confirmed at GP interview.</p> <p>The residential care residents are assessed by needs assessment unit staff for rest home or hospital level of care. Residential care residents are declined entry if their needs assessment does not reflect the services provided at the facility and this is communicated to all concerned.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Acute medical patients' and residential care residents' needs, goals and anticipated outcomes are identified by the assessment process and recorded in their files. Assessments include specialised assessment tools such as: pressure injury assessment; falls assessment; pain assessment; dietary assessment; continence assessment; challenging</p>

		<p>behaviour assessment and interRAI assessments for residential care residents. Patients and residents are assessed at each stage of service delivery and transfer of care.</p> <p>The nursing admission assessment form records initial observations of the acute medical patient on admission and admission assessments and risk screening.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Medical patients' and residential care residents' records reviewed are legible. Communication between health professionals that are involved with care and treatment of a patient or a resident are documented and current. Care plans reviewed demonstrated that staff have completed relevant entries on the care plan to guide individualised care and treatment. Care plans are integrated and promote continuity of service delivery. Caregivers read and sign a form to confirm they have read and understood the long-term care plans of the residential care residents.</p> <p>Patients, residents and family interviewed confirmed staff keep them informed about progress and ongoing care needs.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>There is evidence of allied health involvement as necessary. Interviews with clinical staff and management confirmed there is access to allied health services. Nursing assessments and nursing care plans are completed on specific documents. The medical plans of care and interventions are documented in patients'/residents' progress notes. Clinical record documentation demonstrated that the multidisciplinary team members are describing individualised interventions in patients'/residents' progress notes. Patient and resident interviews confirmed satisfaction with the care and treatment received.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	PA Low	<p>There is a documented activities programme which is implemented for both the rest home and the hospital residents. The activities programme is developed by the activities coordinator (AC) and reviewed by an occupational therapist. Interview with the AC confirmed the programme is implemented from Monday to Friday each week and covers physical, social, recreational, emotional, spiritual and cultural needs of the residents. The AC stated activities are based on the residents' responses, interests, capabilities and cognitive abilities. The residents were observed to be participating in activities on audit days. The</p>

		<p>residents and relatives interviewed reported overall satisfaction with the level and variety of activities provided. Residents' voluntary attendance and participation in activities are recorded.</p> <p>The rest home and hospital residents are assessed to ascertain their social and recreational needs on admission, however, the findings of this activities assessment is not recorded on an activities care plan to meet the identified interests of the individual residents. This is a requirement for improvement.</p> <p>A physiotherapist conducts physiotherapy assessment and mobility plan for both the acute medical patients and residents in the hospital and rest home when then is required. Interview with the physiotherapist confirmed assessments and mobility plans are conducted following a referral from the GP or RNs. This was evidenced in the acute medical patients' files and the hospital and rest home residents' files reviewed.</p> <p>The proposed increase in dual purpose beds will not have an impact of the way the planned activities are implemented, once the required improvement is met.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Medical patients' plans of care and treatments are evaluated on an ongoing basis to monitor progress. Files reviewed have evidence of evaluation occurring by those health professionals involved in the individual patient's care. Evaluation is documented in the progress notes. The frequency of evaluation and reassessment of acute medical patients is based on acuity and progress of the patient. The GP conducts a medical ward round daily for medical patients.</p> <p>Residents care plans record individualised goals and the required interventions. Residents' care plan evaluations occur six monthly or when their condition alters. Where progress is not as expected there is timely assessment and changes made to the patient's care and treatment. Short-term care plans are used for short-term problems. These are evaluated depending on the risk level of the acute care problem.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or</p>	<p>FA</p>	<p>Referrals to other services, specialists and/or clinics are facilitated when required. A copy of the referral information is retained in the patient's or resident's individual record. There was evidence in patient's files</p>

<p>disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		<p>reviewed of the use of the inter-hospital transfer form with all required patient information completed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported in a timely manner. Policies and procedures specify labelling requirements for hazardous material are in line with legislation including the requirements for labels to be clear, accessible to read and free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. Chemicals are stored in a designated shed with chemical hazard signs.</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 was posted in a visible location at the entrance to the facility. There have been no building modifications since the last audit. There are no structural changes required to implement the proposed increase of four dual purpose beds.</p> <p>There was maintenance completed with maintenance requests logged and signed off when completed. While there is not a proactive maintenance schedule, there was active maintenance completed (observed on the days of audit). The service is discussing the location of the services given the need to earthquake proof the inpatient/hospital unit. The general manager has requested an earthquake assessor to establish needs for earthquake proofing.</p> <p>Equipment is available to meet patient needs with a test and tag programme that was up to date. Calibration of medical equipment was completed annually. Interviews with staff confirmed there is adequate and appropriate equipment.</p> <p>There are quiet areas throughout the facility for patients/residents and visitors to meet including resident/patient/family lounges in the rest home and the hospital, and inpatient areas.</p>

		<p>There are safe outside areas that are easy for patients/residents and family members to access. The service provides access to public parking facilities that includes disabled parks. Rails and ramps are appropriately placed to provide support for patients/residents.</p> <p>There is an ambulance entrance in both the inpatient/hospital area and in the rest home area.</p> <p>The rest home is a separate building located close to the inpatient hospital area with a covered walkway to the building.</p>
<p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible toilets/bathing facilities. All toilet facilities have a system that indicates if it is engaged or vacant. Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas and other equipment/accessories are made available to promote resident independence.</p> <p>Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified. There are adequate toilet/shower/bathing facilities to meet the requirements for the proposed four dual purpose beds.</p>
<p><b>Standard 1.4.4: Personal Space/Bed Areas</b></p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Rooms are personalised with furnishings, photos and other personal adornments and the service encourages residents to make the suite their own. There are designated areas to store mobility aids, hoists and wheelchairs.</p> <p>The hospital rooms and assisted care rooms are large enough to accommodate specific aids. There is adequate personal space provided in all bedrooms to allow residents/patients and staff to move around within the room safely. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident/patient.</p>
<p><b>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</b></p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents/patients and staff. Residents/patients can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have ample space for residents/patients.</p>

		Residents/patients can choose to have their meals in their room.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is completed off site, and is delivered daily. Laundry is transported in appropriate colour coded linen bags. Laundry staff sort the personal laundry in the evening and the carers are required to return linen to the rooms. Resident/patients and family members confirmed that the laundry is well managed. There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and are aware that the trolley must be with them at all times. Cleaners were observed keeping the trolley in sight and limiting the chemical cleaning agents on the trolley.</p> <p>All chemicals are in appropriately labelled containers. Training about the use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An evacuation plan has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. A fire drill is conducted six monthly. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. Fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>There is always one RN with a current first aid certificate on duty. A disaster management plan is in place with clear information for staff to follow in the event of an emergency. There are adequate supplies, including food, water, blankets, emergency lighting and gas barbeque.</p> <p>An electronic call bell system is in place. There are call bells in all resident/patient rooms, resident/patient toilets, and communal areas including the hallways and dining rooms. Call bell are checked simultaneously with the hot water temperature checks. Observation on the days of audit and interviews with residents/patients and families confirmed there are prompt responses to call bells. Sensor mats are used where appropriate.</p> <p>There are curtains around both beds in the new double rooms and both beds have call bells.</p>
Standard 1.4.8: Natural Light, Ventilation, And Heating	FA	There are procedures to ensure the service is responsive to

<p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>		<p>resident/patient feedback in relation to heating and ventilation, wherever practicable. Residents/patients are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature. Families and residents/patients confirmed that rooms are maintained at an appropriate temperature.</p>
<p><b>Standard 3.1: Infection control management</b></p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The infection control programme and the role of the infection control team is documented. The infection control representatives are the CNM and the assistant manager of older person's health. The infection control programme is reviewed annually. The CNM interviewed confirmed their input into the management of infection control at the facility.</p> <p>The delegation of infection control matters is documented in policies. There is evidence of regular reports on infection related issues and these are communicated to staff and management. Staff, patients and residents suffering from infectious disease are prevented from exposing others while infectious.</p> <p>The proposed increase in dual purpose beds will not have an impact of the way the infection control management system is implemented at the facility.</p>
<p><b>Standard 3.2: Implementing the infection control programme</b></p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	<p>FA</p>	<p>The infection prevention and control programme and policies and procedures meet the needs of the organisation and provide information and resources to inform and guide staff.</p> <p>The infection prevention and control representatives are qualified health professionals with relevant skills, who have access to residents/patients records and diagnostic results, as required. Regular reports on infection related issues are recorded by regular monitoring systems. Implementation of the infection prevention and control programme is monitored via internal audits.</p> <p>The clinical staff screen new admissions for any potentially infectious illnesses that may lead to transmission. The requirement for isolation is identified on each patient's/resident's admission and continued in the ward. Staff know the precautions that are required and have received infection prevention and control education. Staff were observed to wear protective clothing and taking the required precautions.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control management systems are supported by policies, procedures and guidelines. The policies and procedures reflect current accepted good practice, safety and relevant legislative requirements.</p> <p>Policies are readily accessible to all personnel, confirmed at staff interviews. The infection prevention and control policies and procedures are developed and reviewed regularly in consultation and input from relevant staff, and identify links to other documentation in the facility.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection prevention and control education is provided to new staff at orientation. An infection prevention and control questionnaire and online infection prevention and control training is available and completed by staff. Participation in questionnaires and online training in infection control is evidenced in staff records.</p> <p>The infection prevention and control representatives are resource persons for patients, residents, family and other health professionals, as confirmed at staff interviews. Care needs and education of patients/residents is individually met in relation to infection prevention and control, confirmed at interviews and interview with a patient who required isolation. Infection prevention and control representatives have completed education relating to infection control.</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>Surveillance of infections is carried out that is appropriate to the acute care services and the residential care services at the facility. The surveillance data sighted evidenced surveillance is recorded for the medical ward, long-term hospital care, and the rest home.</p> <p>The infection prevention and control representatives are responsible for gathering, monitoring and collating the surveillance information and for reporting the results to staff and management. The outcomes are fed back to the staff at staff meetings, with any immediate risks reported at handovers and to management. Trends and recommendations are communicated to clinical staff. Minutes of meetings are maintained.</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 minimisation policy is documented and implemented. The definitions of restraint and enablers are consistent with this standard. Records sampled confirm that staff actively work to minimise the use of</p>

minimised.		<p>restraint. The role of the restraint coordinator is shared between the clinical nurse manager and the assistant manager of older persons' health.</p> <p>There were four residents assessed as requiring restraint and no residents/patients requesting the use of enablers on audit days. The use of enablers is voluntary. Staff and management interviews confirmed awareness of restraint and enabler use.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval process policy is documented and implemented.</p> <p>The use of restraint is approved by the clinical team the family and the GP. The approval process requires an assessment of risk and evidence of trialled alternatives. The required approvals were sighted in restraint records sampled.</p>
<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	<p>A restraint risk assessment tool is completed for each identified restraint used. The restraint assessment process is fully documented and includes the requirements of this standard. Resident records sampled confirmed completed assessments and approvals. The most common reason for implementing a restraint in the records samples was for safety reasons.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraints are used as a last resort. Discussions regarding trialled alternatives were sighted in records sampled. Once in place, restraints are monitored for safety. The residents requiring restraint are monitored, as confirmed at interviews. There have been no reported incidents related to unsafe restraint use. Restraints were observed to be in safe use during the audit.</p> <p>The restraint care plans record the risks associated with restraint use and a plan of care is recorded.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>Restraint use is evaluated during the care plan review process. In the event it is considered the resident/patient may be able to discontinue using the restraint, the process is to remove the restraint and monitor the resident/patient to ensure ongoing safety.</p>

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Quality review of restraint use policy is conducted. Compliance with the restraint policy and procedure is monitored by management. Staff are trained in de-escalation techniques and restraint minimisation practices. This was confirmed at staff and management interviews and in staff files.</p>
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	Staff and residents/patients interviewed understood the complaints process. A complaints register was in place to document complaints. The complaints policy does not include reference to a process to manage verbal complaints and verbal complaints are not consistently recorded on the complaints register.	A verbal complaints process is not documented in the policy and verbal complaints are not consistently recorded in the complaints register.	<p>Ensure there is a documented process included in the complaints policy to manage verbal complaints and all complaints are documented in the complaints register with the outcomes included.</p> <p>180 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Staff understand the processes for reporting incidents, accidents and near misses, however, not all unobserved falls had neurological observations completed and/or recorded. The incident and accident records reviewed showed designations of staff are not consistently recorded.	<p>i) Review of resident files showed that incident/accident records for unobserved falls do not consistently reflect completion of neurological observations.</p> <p>ii) Four of five incident/accident records reviewed did not have</p>	<p>i) All unobserved falls to have neurological observations completed and recorded.</p> <p>ii) Staff to consistently record their designations when making entries to incident/accident records.</p>

			designations recorded by the staff who completed the records.	180 days
<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>Medication files reviewed evidenced: allergies were recorded; prescriptions were either written or typed by the GP and each entry signed by the GP; and discontinued medications dated and signed by the GP. The rest home and hospital residents' photo identifications were located in the medication folders.</p> <p>Medication files sample was increased from 12 to 17. There was evidence of the 'as required medications' charted not consistently recording the maximum doses or indications of use in both the residential care residents' medication files and the acute medical patients' charts.</p> <p>The three monthly medication reviews were not consistently recorded on the medication charts for the residents.</p>	<p>The medication files evidenced the 'as required medication' did not consistently record maximum doses and indication of use. The residents' medication charts did not consistently record three monthly medication reviews.</p>	<p>Provide evidence the 'as required medication' record maximum doses and indication of use and the residents' medication charts record three monthly medication reviews.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Low</p>	<p>The GP initial assessments of rest home and hospital residents are conducted within the required timeframes. The residents are examined three monthly or as clinically indicated. The files reviewed did not consistently record the resident's medical condition as stable as assessed by the GP for the resident to be examined less frequently than monthly. This exception is not always noted and signed by the GP in the residents' medical records.</p>	<p>The GP exceptions are not always completed for residents to be examined less frequently than monthly.</p>	<p>Provide evidence the GP exceptions are completed in the residents' medical records for residents to be examined by the GP less frequently than monthly.</p> <p>180 days</p>

<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>The AC conducts an activities assessment for each hospital and rest home resident, however, this information is not recorded on an individualised activities plan for the resident. The hospital and rest home residents' nursing care plans evidenced some of the residents' identified interests were recorded within the care plans, however, not all interests were included.</p>	<p>The hospital and rest home residents' files reviewed did not evidence an activities care plan to meet the residents' identified interests, preferences or level of ability.</p>	<p>i) Provide evidence each hospital and rest home resident has a written and implemented social and recreational plan of activities planned to meet their identified interests, preferences or level of ability.</p> <p>ii) Provide evidence the plan is evaluated and reviewed each time the care plan is reviewed.</p> <p>180 days</p>
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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.

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End of the report.