

Elms Court Rest Home Limited

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Elms Court Rest Home Limited

Premises audited: Elms Court Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 30 May 2017 End date: 31 May 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: 19

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

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

General overview of the audit

Elms Court Rest Home is privately owned and operated. The service provides care for up to 19 residents at rest home level of care with 19 residents living at the facility at the time of the audit.

This surveillance audit was conducted against aspects of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, interviews with residents, family, management, staff and a general practitioner.

The service is managed by the owner who has been in the role for two years. He is supported by a registered nurse, who works two days per week.

The one shortfall identified at the previous certification audit around infection control surveillance has been addressed.

This audit identified improvements required around: respectful communication; documentation of complaints; training for the manager; registered nurse follow up of incidents; interRAI contractual obligations; review of assessment tools; regular review of residents by the registered nurse; documentation of GP reviews; having sufficient registered nursing hours; pain monitoring; documenting the effectiveness of 'as required' medication; other monitoring records; medication management; and end point food temperatures.

Consumer rights

<p>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.</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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A policy on open disclosure is in place. There is evidence that residents and family are kept informed. A system for managing complaints is in place.

Organisational management

<p>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.</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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Quality and risk management processes continue to be maintained. Corrective action plans are implemented where opportunities for improvement are identified. A health and safety programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes. Residents receive services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place

for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided for 13 hours per week. There are adequate numbers of caregivers on duty to ensure residents are safe.

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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The registered nurse assesses and develops the care plan documenting support, needs, goals and outcomes with the resident and/or family/whānau input. Care plans reviewed demonstrated service integration and had been evaluated six-monthly. Resident files included review by the general practitioner, specialist and allied health services.

An activities coordinator coordinates the activity programme. The programme includes community engagement and outings, entertainment and activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each resident. Residents are encouraged to maintain links with community groups.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medicines complete medication competencies and annual education. The general practitioner reviews medications three-monthly.

Resident food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures in place. Staff receive training in restraint minimisation and challenging behaviour management. The service maintains a restraint-free environment and no residents are currently utilising enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	7	0	4	5	0	0
Criteria	0	29	0	5	5	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	PA Low	<p>A complaints policy and procedures is documented and their family/whānau have been provided with information on admission. Complaint forms are available at the entrance foyer. Staff are aware of the complaints process and to whom they should direct complaints. A complaints folder has been maintained and contains one complaint for 2016 and 2017 YTD. The manager reported that minor complaints are not recorded and are dealt with as they occur. There has been one complaint documented since the previous audit. This complaint has been resolved within appropriate timeframes. An investigation and outcome were documented. Residents advised that they are aware of the complaints procedure and how to access forms. The 2016 resident survey identified that not all residents were familiar with how to complain and following this information, on how to complain was provided at the following two resident meetings.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an</p>	PA Moderate	<p>Residents and interviewed (seven) stated that their family are informed of changes in health status and incidents/accidents. Incidents are all documented and include an area to identify if family are informed. A review of incident forms and progress notes identify family have been kept informed. No family were available to be interviewed.</p> <p>Residents interviewed also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur three-monthly and the management team have an open-door</p>

<p>environment conducive to effective communication.</p>		<p>policy.</p> <p>The facility is small and there is ongoing communication between the manager, staff, residents and families. Interviews identified that communication is not always polite and respectful.</p> <p>Resident meetings are held three-monthly and are an avenue for communication between staff, management and residents.</p> <p>Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service has policies and procedures available for access to interpreter services for residents (and their family/whānau). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>PA Low</p>	<p>The service provides care for up to 19 residents requiring rest home level care. On the day of the audit, there were nineteen residents in total (including one resident who is currently paying privately while waiting for a NASC assessment (the manager reports a referral has been made); two residents on younger persons with disability (YPD) contracts; and two residents on long term support– chronic health conditions (LTS – CHC) contracts). All other residents were under the aged residential care (ARC) contract.</p> <p>The service is managed by a manager who is experienced in the industry and has worked at the facility prior to becoming manager two years ago. The manager has previously worked in the social service area. In the past year, he has completed training around the Eden philosophy but not relating to the management of a rest home. The manager is supported by a part time registered nurse.</p> <p>Elms Court has a business/quality plan that includes goals for 2016 and 2017 and review of previous goals.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality</p>	<p>FA</p>	<p>The service continues to implement a quality and risk management system. A system for document control is in place. Any new policies or changes to policy are communicated to staff, evidenced in meeting minutes and in interviews with staff. The organisation is in the process of reviewing and updating their internal audits to align with policies and procedures that have been updated.</p> <p>Key components of the quality management system include (but are not limited to): monitoring falls; medication errors; other incidents; infections; and resident and relative satisfaction. There are monthly accident/incident reports and infection reports that are discussed at the three-monthly management meetings and three-monthly staff meetings. Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>A health and safety programme in place with strategies implemented to promote a safe work place. The manager is the designated health and safety coordinator. Health & safety is discussed at management and at staff meetings.</p>

<p>improvement principles.</p>		<p>All staff complete an annual manual handling competency. There is a hazard register that has been updated in 2017.</p> <p>Resident meetings also occur three-monthly. A family satisfaction survey was last completed in 2016 with three relatives returning the questionnaire (many residents do not have significant family engagement). A resident satisfaction survey had recently been completed by eight residents but not yet collated. The 2016 survey (also completed by eight residents) identified that residents are generally happy with the service they receive. A corrective action was implemented around resident understanding of the complaints process.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>PA Moderate</p>	<p>Discussions with the service confirm that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p> <p>The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the staff. Individual incident reports are completed for each incident/accident. These are reviewed by the manager (non-clinical) and the registered nurse signs them off when she is next on duty. There was no documented follow up by the registered nurse for any of the 13 incident forms sampled (from March to May 2017). Neurological observations were not completed following a head injury.</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</p>	<p>FA</p>	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Five staff files were reviewed (the registered nurse and four caregivers) included evidence of the recruitment process, signed employment contracts, police vetting and completed orientation programmes and annual performance appraisals. Staff turnover was reported as moderate.</p> <p>The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that they believed new staff were adequately orientated to the service.</p> <p>The registered nurse has recently qualified as a Careerforce assessor and all staff are working towards a national caregiving qualification.</p> <p>A completed in-service calendar for 2016 exceeded eight hours annually. There is a structured education</p>

legislation.		programme for all staff that includes six-monthly training days that cover all required topics each year. Competencies including, but not limited to: infection control; medication; restraint minimisation; and manual handling are completed annually for staff. All staff have a current first aid certificate. The registered nurse has completed interRAI training.
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	Elms Court has an ongoing roster in place that was last reviewed on 8 May 2017. Staff work regular shifts. There is one caregiver on duty 24 hours per day with a second caregiver between 7 am and 10 am and between 3.30pm and 6.30pm. The registered nurse works thirteen hours per week over two days and is on call the rest of the time. This time is insufficient to complete all required documentation (link 1.3.3.3, 1.3.3.4 and 1.3.4.3). There is a casual RN who covers leave for the RN. In addition, the manager also works five days a week and a cook provides the meal. Caregivers interviewed (two) advised that sufficient caregivers are rostered on for each shift.
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	Medications are stored in the staff office in a locked trolley and cupboard. Controlled drugs are managed and stored safely but regular weekly checks have not always occurred. Staff responsible for the administering of medication complete annual medication competencies and attend annual medication education. However, both staff observed administering medication did not follow correct process. The service uses individualised blister packs for all medications. Medications are checked on delivery against the medication chart by the RN. Medication trolley contents were all within expiry dates and all eye drops are discarded by the registered nurse every month. There were two residents self-administering medications. Both had a current competency assessment around this. 'As required' medications have the date and time of administration recorded on the signing sheet but the indication for use was not always documented by the prescriber. Eight of ten medication records sampled documented the resident's allergy status and six of ten had all prescribed medications signed as administered.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs	PA Low	A staff member is employed Monday to Friday to cook meals. The main meals provided for residents on the two days of the audit were of a high standard 'home cooked' style meal. There is a four-weekly seasonal menu that was reviewed by a dietitian in 2015. The cook receives a resident dietary profile for all new admissions and is notified of dietary changes as needed. The kitchen is open-plan on to the dining room and residents provide feedback about meals directly to the cook during the meal (observed at lunchtime). Specific cultural preferences are met. Resident likes, dislikes and dietary preferences are known. Food is served directly from the kitchen to the dining room. The fridge and freezer temperatures are monitored daily. Food temperatures are monitored for the main meal but this had recently ceased. The evening meal is reheated by caregivers but an end point temperature is not recorded. All

<p>are met where this service is a component of service delivery.</p>		<p>foods were date labelled. A cleaning schedule is maintained. Feedback on the service was received from resident and staff meetings, surveys and audits. Staff have been trained in safe food handling and chemical safety. Residents interviewed spoke positively about the meals provided.</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>	<p>PA Moderate</p>	<p>Residents interviewed reported their needs were generally being met. When a resident's condition alters, the registered nurse, a caregiver or the manager initiates a review and if required a GP visit.</p> <p>Dressing supplies are available and treatment rooms are adequately stocked for use. There were no wounds at the time of the audit.</p> <p>Contenance products are available and resident files include a three-day urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RN interviewed.</p> <p>Monitoring forms in place include monthly weight, blood pressure and pulse records. One food and fluid chart available had not been fully completed or reviewed. Pain monitoring and documenting the efficacy of 'as required' medications was not occurring.</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>	<p>FA</p>	<p>The activities coordinator provides an activities programme two days each week and coordinates with the manager and caregivers around activities on other days. A diversional therapist takes residents on an outing one day per week. The manager arranges and takes residents to a variety of community events. Many residents attend local clubs and travel around the city by bus (for those that are able). During the 1 ½ day audit, activities witnessed included (but were not limited to): two residents being taken to the mall; one resident being taken to a café for coffee by a caregiver; six residents attending a concert; and two residents busing to Sumner for lunch. The programme is planned weekly and activities are made known to residents.</p> <p>A diversional therapy plan is developed for each individual resident, based on assessed needs. Residents are encouraged to join in activities that were appropriate and meaningful and are encouraged to participate in community activities. The service has a van that is used for resident outings. Residents were observed participating in activities on the days of audit. Resident meetings provided a forum for feedback relating to activities. Residents interviewed discussed enjoyment in the programme and the diversity offered to all residents.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service</p>	<p>FA</p>	<p>Care plans reviewed were updated as resident's care requirements changed. Care plan evaluations reviewed were comprehensive, related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Short-term care requirements for residents are incorporated into the long-term care plan and were</p>

delivery plans are evaluated in a comprehensive and timely manner.		dated and signed. Care plans sampled were evaluated within the required timeframes.
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 service displays a current building warrant of fitness. Regular and reactive maintenance occurs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	Infection surveillance and monitoring is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection and monitoring also occurs of antibiotic prescribing. Surveillance of all infections is entered on to a monthly infection summary, analysed for trends and staff informed. This is an improvement since the previous audit. There have been no outbreaks since previous audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service has maintained a restraint-free environment and no residents use enablers. Restraint minimisation is discussed at management and staff meetings and all staff complete an annual restraint competency. The restraint minimisation policy includes restraint/enabler procedures. There is a documented definition of restraint and enablers which is congruent with the definition in the standard.

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	There is a documented complaints process and ‘serious’ complaints are documented (one in 2016 and 2017 YTD). The manager reports that minor complaints are addressed but not documented. Since the audit, the complaints policy has been updated to include the documentation of all complaints and staff have been informed of the updated policy and the need to record all complaints (staff meeting minutes sighted).	Complaints perceived as minor by the manager are not documented using the complaints process.	<p>Ensure all complaints are included in the complaint register with actions and resolutions documented.</p> <p>90 days</p>
<p>Criterion 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure</p>	PA Moderate	The facility is small and management and staff communicate with residents throughout the day. The manager is present most days during the week. The resident group is vulnerable and many residents have spent much of their life in institutions. Residents	Three of three care staff and three of seven residents interviewed reported that communication between management and residents is not always respectful.	Ensure that all communication between management and residents is polite and respectful and that this is confirmed by

from service providers.		interviewed reported that the manager assists them in many ways. On the day of the audit, one resident was being provided a new bed. The GP reported that staff and residents go the extra mile for residents in this family-like environment. Care staff (two caregivers and the registered nurse) and some residents interviewed reported that communication between management and residents is not always respectful.		staff and resident feedback. 30 days
Criterion 1.2.1.3 The organisation is managed by a suitably qualified and/or experienced person with authority, accountability, and responsibility for the provision of services.	PA Low	The manager has completed a four-day training in 2017 relating to the implementation of the Eden philosophy but has not completed training regarding management of a rest home. The manager has completed health and safety training.	The manager has not completed the contractually required eight hours of training related to management of a rest home	Ensure the manager completes eight hours of education relating to rest home management each year. 90 days
Criterion 1.2.4.3 The service provider documents adverse, unplanned, or untoward events including service shortfalls in	PA Moderate	When an incident occurs, care staff complete an incident form. For serious incidents, the manager (non-clinical) is contacted and for issues requiring clinical input, the registered nurse is contacted. All incident forms are reviewed by the manager and the manager determines if any corrective action is required. No incident forms of the 13 sampled, identified a need for follow up or any action to reduce the likelihood of	There was no documented evidence of clinical follow up or review of residents following incidents including neurological observations following a knock to the head. One resident had a fall resulting in injury, including pain. Four days after the incident, the resident requested an ambulance be called due to severe pain. The pain was recorded in progress notes. There was no documented clinical follow up and the registered nurse reported not being aware	Ensure all residents have clinical follow up when an incident has occurred and that this is recorded. 60 days

order to identify opportunities to improve service delivery, and to identify and manage risk.		recurrence. The registered nurse views and signs off the incident forms when she is next on duty. There was no evidence of clinical follow up of residents following incidents.	the resident was in pain until after the resident was transferred to hospital.	
Criterion 1.2.8.1 There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.	PA Low	The registered nurse works thirteen hours per week over two days. The RN described attending to urgent matters and completing and reviewing care plans but insufficient time for review of incident forms (link 1.2.4.3), interRAI assessments (link 1.3.3.3) and regular review of all residents (link 1.3.3.4). Since the audit, the registered nurse has been rostered for four additional hours on each Saturday (revised roster sighted).	There were insufficient registered nursing hours for all required tasks and regular review of residents to be completed and documented.	Ensure the registered nurse is employed for sufficient hours to complete all tasks requiring registered nurse input. 60 days
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in	PA Moderate	All staff have been assessed as competent to administer medication. However, the two staff observed, did not follow the correct practice and prescribed medications are not always documented as administered. Allergy status was documented by either the GP or the registered nurse on eight of ten charts sampled. The service has a process to safely manage controlled medications when only one staff member is on duty, but weekly physical checks had not always occurred. Medication prescribing met legislative requirements except around indications for use for 'as required' medications.	(i) Two staff members observed administering medications, did not carry the medication charts or administration records. Medications administered were not checked against the prescription or signed as administered following administration. (ii) Two of ten medication charts sampled did not have the allergy status documented. (iii) Two of ten medication charts sampled did not have indications for use documented and one further chart had a medication on the medication chart documented as regular, when the administration sheet states 'as required'. (iv) Four of ten medication charts sampled did not have all prescribed medications signed as administered. (v) Controlled drug weekly checks have not always occurred.	(i) Ensure that staff undertaking medication administration do so in a safe manner. (ii) Ensure the allergy status is documented for all residents. (iii) Ensure medication charts are accurate and document the indication for 'as required' medication. (iv) Ensure medications are administered as prescribed. (v) Ensure

order to comply with legislation, protocols, and guidelines.				weekly physical checks of controlled drugs occur. 30 days
Criterion 1.3.13.5 All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.	PA Low	All meals are cooked in a large 'domestic' type kitchen that is open-plan with the adjacent kitchen. The cook prepares the evening meal and this is reheated by caregivers. The end point temperatures have not been recorded for the main meal recently and are not recorded after reheating for evening meals.	(i)End point cooking temperatures for the main meal had not been completed since 18 May 2017. (ii)End point re heating temperatures are not taken for food reheated for the evening meal.	(i)Ensure end point cooking temperatures are recorded for the main and evening meals. 60 days
Criterion 1.3.3.3 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.	PA Low	Every file sampled (five) contained an initial assessment and care plan completed on the day of admission. The registered nurse reported the manager attempts to arrange admission on a day she works. All long-term care plans had been reviewed six-monthly. Two of the three files sampled had an interRAI assessment completed in 2015 and the other had not had an interRAI assessment. Three of the five files reviewed had the paper based assessments completed six-monthly.	(i)Three of three files for residents on the ARC contract have not had contractual obligations around interRAI adhered to. (ii)Two residents (one a YPD contract) has not had clinical assessments reviewed six-monthly.	(i)Ensure interRAI contractual obligations are met. (ii)Ensure all risk assessments are reviewed at least six-monthly. 90 days

<p>Criterion 1.3.3.4</p> <p>The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate.</p>	<p>PA Moderate</p>	<p>Caregivers document progress notes that are detailed at least twice in every 24 hours. There are not regular entries from the registered nurse. When the GP visits the facility, a handwritten note is documented in the residents file. When the resident is taken to the GP rooms, this is not always recorded in the residents file. Medication chart review dates confirm that the GP did review the residents.</p>	<p>(i)Five of five progress notes sampled did not document regular review of residents by the registered nurse. For example, two files did not have a documented progress note by the registered nurse in 2017 and another did not have a progress note following discharge from hospital.</p> <p>(ii)Two residents who visit the GP with family or alone on occasion do not have a record of all GP visits in the file.</p>	<p>(i)Ensure all residents are regularly reviewed by the registered nurses and that this is documented.</p> <p>(Ensure that GP visit notes are kept in the residents file.</p> <p>30 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Moderate</p>	<p>Files sampled demonstrated that weight monitoring, blood pressure and pulse monitoring occur monthly. Pain monitoring and effectiveness of 'as required' medications were not being documented. The management of the fluid balance chart sampled required improvement.</p>	<p>(i)Residents requiring 'as required' medication for pain, including opiate pain relief, did not have regular pain monitoring completed.</p> <p>(ii)The efficacy of 'as required' medication was not documented.</p> <p>(iii)One fluid balance chart was sighted. This had not been regularly completed, had not been totalled each day and had not been reviewed by the registered nurse.</p>	<p>(i)Ensure regular pain monitoring occurs for residents with pain.</p> <p>(ii)Ensure the efficacy of 'as required' medication is documented.</p> <p>(ii)Ensure fluid balance charts are accurately recorded, balanced every 24 hours and reviewed regularly by the registered nurse.</p> <p>60 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.