# CHT Healthcare Trust - St Johns

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** CHT Healthcare Trust

**Premises audited:** St Johns Hospital

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

**Dates of audit:** Start date: 27 September 2017 End date: 27 September 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:** 89

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

## General overview of the audit

CHT St Johns provides hospital (geriatric and medical), dementia and residential disability – physical levels of care for up to 90 residents and on the day of the audit there were 89 residents. A unit manager, who is well qualified and experienced for the role, oversees the service. She is supported by a clinical coordinator/registered nurse and an area manager. The residents and relatives interviewed all spoke positively about the care and support provided.

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

The service has addressed four of five shortfalls following a partial provisional audit around building requirements in the new dementia wing, a secure external area for dementia level residents, a fire evacuation plan and installation of a call bell system in the dementia wing. Improvements continue to be required in relation to the outdoor area for dementia residents.

This surveillance audit identified that improvements are required in relation to medication management.

## Consumer rights

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

There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

## Organisational management

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

CHT St Johns has a current business plan and a quality assurance and risk management programme that outlines objectives for the year. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management.

Aspects of quality information are reported to three monthly combined staff and quality meetings. Residents and relatives are provided with the opportunity to feedback on service delivery issues at resident meetings and via satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings.

Job descriptions are in place for all positions that include the role and responsibilities of the position. There is an annual in-service training programme and staff are supported to undertake external training. The service has a documented rationale for determining staffing and healthcare assistants, residents and family members report staffing levels are sufficient to meet residents’ needs.

## Continuum of service delivery

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

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for assessment, care planning and evaluation of care, with input from residents and family. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident’s assessed needs and abilities and residents advised satisfaction with the activities programme.

There is a secure medication system at the facility. Staff responsible for medication administration are trained and annual competencies are completed.

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

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

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

## Restraint minimisation and safe practice

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

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There were eight residents with restraint and three residents with enablers at the time of audit. Staff have received education and training in restraint minimisation and managing challenging behaviours.

## Infection prevention and control

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

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. Infection rates are low.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 15 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 41 | 0 | 2 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of the complaints process. Complaints forms are in an accessible and visible location. Information about the complaints process is provided on admission. All managers (one area manager and one unit manager) and twelve care staff interviewed (four healthcare assistants (HCAs), six registered nurses (RNs) and two activities coordinators) were able to describe the process around reporting complaints.  There is a complaints’ register. Verbal and written complaints are documented and include any concerns identified in the resident satisfaction surveys. Fifty-nine complaints have been lodged in 2017 (year-to-date). Twelve complaints received in July and August 2017 were reviewed. All 12 complaints had a documented investigation. Timeframes for addressing each complaint were compliant with the Health and Disability Commissioner (HDC) guidelines and corrective actions (when required) were documented. Two complaints were open. One complaint from a family member around resident cares had been lodged with HDC (28 July 2017) and is currently under investigation. Another complaint received (8 August 2017) around resident cares and wound management had been lodged with the Auckland District Health Board (ADHB) and is under investigation. Corrective actions addressing these complaints have been implemented.  Complaints received are discussed in the quarterly quality meetings. Interviews with residents confirmed that any issues that are raised are addressed and that they feel comfortable bringing up concerns. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Six hospital level residents interviewed (including two residents on the young persons with a disability (YPD) contract) stated that they were welcomed on entry and were given time and explanation about the services and procedures. The YPD residents’ specific communication requirements are being met by the service. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs.  Fifteen incident/accident forms were selected for review. The form includes a section to record family notification. All 15 forms reviewed indicated family were informed. Two families interviewed (one hospital, one dementia) confirmed they are notified of any changes in their family member’s health status. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | St Johns is owned and operated by the CHT Healthcare Trust. The service provides residential care for up to 90 residents. This includes dementia level of care (20 beds) and hospital level of care (geriatric and medical) (70 beds). Hospital level of care encompasses certification to provide residential disability (physical). On the day of the audit there were 89 residents (20 dementia and 69 hospital). Five residents (hospital) were on the young person with a disability (YPD) contract. All other residents were under the age related residential care contract.  The unit manager is a registered nurse (RN) and maintains an annual practicing certificate. She has been the unit manager at St Johns for 10 years. The clinical coordinator/RN has been in the role since November 2005.  St John’s has a performance plan that lists performance goals for the facility that are centred on strategic themes. The format for this plan has recently been updated. The unit manager reports monthly (at a minimum) to the area manager regarding progress towards meeting goals.  The unit manager has completed in excess of eight hours of professional development in the past 12 months. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is evidence that the quality system continues to be implemented at the service. Interviews with managers and staff, and review of the quarterly quality meetings confirmed that quality data is discussed at three monthly quality/health and safety/staff meetings to which all staff are invited. The unit manager advised that she is responsible for providing oversight of the quality programme.  The service's policies are reviewed at national level with input from facility staff every two years. New/updated policies are sent from head office. Staff have access to manuals.  Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. There are three health and safety representatives (one activities coordinator - am shift, one HCA - pm shift and one HCA - night shift). Staff complete a hazard reporting form when a hazard is identified. Controls are in place to minimise hazards. Hazard controls are regularly reviewed.  Falls prevention strategies are implemented for individual residents and staff receive training to support falls prevention. Residents are surveyed regularly to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an accidents and incidents reporting policy. The unit manager and clinical coordinator investigate accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at three-monthly quality/health and safety/staff meetings including actions to minimise recurrence.  Fifteen incident forms that were sampled documented clinical follow-up of residents, which are conducted by an RN. Neurological observations are completed when there is a suspected injury to the head.  Discussions with the unit manager confirmed her awareness of the requirement to notify relevant authorities in relation to essential notifications with examples provided. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | There are human resource management policies in place. The recruitment and staff selection process requires that relevant checks are completed to validate the individual’s qualifications, experience and veracity. A copy of practising certificates is kept. Six staff files reviewed (three RNs, three healthcare assistants (HCAs)) evidenced that interviews and reference checks are completed before employment is offered. All new employees undergo police vetting.  The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2017 is being implemented and meets contractual requirements. Staff undergo annual performance appraisals. HCAs have completed an aged care education programme. Ten of fourteen HCAs who routinely work in the dementia unit have completed their required dementia qualification. The remaining four are enrolled and have been working in the dementia unit for less than one year.  The unit manager and registered nurses are able to attend external training including sessions provided by the local DHB. Seven of eleven RNs are interRAI trained. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | CHT policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents.  The facility layout includes ten clusters of residents’ rooms (referred to as pods). Five (hospital level) pods have eight beds in each pod. The 20 dementia level beds are located in two (10 room) secure pods and the remaining (three) hospital level pods have ten beds in each pod. There were 20 dementia level residents and 69 hospital level residents during the audit.  In addition to the unit manager (RN) and clinical coordinator (RN) who work Monday – Friday, three RNs are rostered on the AM shift, seven days a week, two RNs on the PM shift and one RN on the night shift. The RNs and activities staff hold current CPR certification. One rostered RN is scheduled in the dementia unit (occupancy 20) from 12pm – 7pm Monday – Friday and 12pm to 6pm on weekends. For the remaining times, the RNs are based in the hospital pods and oversee the dementia level residents.  There are 10 pods in total, five with 8 beds and five with 10 beds.  Dementia with 20 residents: (2-ten bed pods):AM: 3 HCAs (two long shifts and one short shift; PM: 2 HCAs long and Night: one HCA  Hospital with 69 residents:(5- eight bed pods and 3 ten bed pods): There is one HCA per each pod for the AM and PM shifts with four HCAs total covering all pods during the night shift. Six HCAs work short shifts on the AM shift (three in the eight bed pods and three in the 10 bed pods) and two short shifts cover the PM pods (one for the eight bed pods and one for the ten bed pods).  Activities: two staff Monday - Friday from 9-3 and weekends from 10-3  Adequate numbers of HCAs are rostered with a minimum of five HCAs rostered on the night shift (one in the dementia unit and four in the hospital pods). The unit manager reported that staff are shifted to different pods for increased resident requirements.  Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Click here to enter text |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | CHT St Johns has a commercial kitchen where all food is prepared by an external company. All kitchen staff had completed food safety training. The kitchen manager (interviewed) explained the procurement of the food and management of the kitchen, for which he is responsible. On the day of the audit, meals were observed to be hot and well presented. Food is transported to each suite via hot boxes. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge, food, freezer and dishwasher temperatures were monitored and documented daily and were within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. Nutritional profiles were evident in a folder for kitchen staff to access. Special diets were noted on the kitchen noticeboard. The menu is a four-weekly seasonal menu. The service continues tom implement the Replenish Energy and Protein (REAP) programme. REAP puts a focus on nutrition and 'nutrition alerts'. The documented programme has been developed by the external contractors’ dietitian and provides eligibility criteria and implementation guidelines for each level of REAP. The emphasis is on food first rather than commercial supplements for managing unintended weight loss. Residents and families interviewed, expressed satisfaction with the food service and provide feedback through a food survey and at resident and relative meetings. Resident weights are monitored monthly or more frequently if required. Dietary supplements are available.  A ‘finger foods’ programme has been developed to ensure the needs of dementia residents are met and snacks are available in the dementia unit 24 hours per day. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Six files were reviewed for the audit. The interRAI assessment informs the LTCP. Care plan documentation included input from allied health and other specialists. Residents and family/whānau members interviewed expressed satisfaction with the clinical care and that they are involved in the care planning of their family member.  Healthcare assistants and the RNs interviewed state there is adequate equipment provided including continence and wound care supplies.  Wound assessment, monitoring, and wound management plans are in place for twelve residents with wounds (including two chronic wounds and four residents with grade two pressure injuries). All wounds had been reviewed in appropriate timeframes.  Monitoring charts were in use and examples sighted included (but not limited to), weight and vital signs, blood glucose, pain, food and fluid, repositioning charts and behaviour monitoring as required. Short-term care plans (STCPs) are in place for all short-term needs.  Additional assessments for management of behaviour were appropriately completed according to need. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | Four activities coordinators are employed part-time and assist with activities across a seven-day week. The activities programme is designed for high-end and low-end cognitive functions and caters for individual needs. The programme is developed monthly and displayed in large print. Residents have an activities assessment and lifestyle map completed over the first few weeks after admission, obtaining a complete history of past and present interests, career and family history. Resident files reviewed identified that the individual activity plan was reviewed at least six-monthly. The activities coordinators (ACs) interviewed explained the variety of the programme and the inclusion of exercise activities. There was evidence of community involvement. The ACs explained they held four open days per year where community was invited in. There was a grandparents and grandchildren day and St Patricks Day. They celebrated cultural days with staff and residents preparing for the event. Staff worked with residents and families to hold a ‘this is your life’ celebration as a voluntary event. The young person with a disabilities have an individualised and specific programme to meet their needs (see 1.3.3 tracer). On the day of audit, residents were observed being actively involved in activities. Residents can attend any of the activities on offer with some dementia residents attending activities held in the hospital. There are pet therapy days and the facility has a resident cat and budgies. Residents and family interviewed were satisfied with the activities provided. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plans are evaluated by the registered nurse six-monthly. All care plans sampled were updated when changes to care occur. Short-term care plans for short-term needs were evaluated and either resolved or added to the care plan as an ongoing problem. There is at least a three-monthly medical review by the medical practitioner. The family members interviewed confirmed they are invited to attend GP visits. Progress notes are updated daily or as health changes. Registered nurse input and review after significant events and health changes was evident in the progress notes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | PA Low | A current building warrant of fitness is posted in a visible location (expiry 19 October 2017) and the new building is fully completed to a high standard. These are improvements since the previous audit. Water temperatures for a random selection of residents’ rooms in each area (pod) are checked and recorded monthly. These are maintained between 43 and 45 degrees Celsius. This includes the dementia unit. There were no instances identified where water temperatures exceeded 45 degrees Celsius. Floor and window coverings and fixtures in the dementia unit are installed. The dementia area is secured. The entrance dividing the unit from the rest of the facility is secured by keypad locks on double doors. This is an improvement since the previous audit. Hazards identified during the partial provisional audit (eg, fuse box, fire hoses, hot water taps) are being controlled. The outdoor area for dementia level residents is secure and landscaping has been completed around the new hospital areas. These are improvements from the previous (partial provisional) audit.  Key pad access has been installed in two locations in the dementia areas and has resulted in limiting access for residents to move freely to the secure outdoor area. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | An approved fire evacuation plan was sighted (dated 4 May 2016). Emergency call bells alarms have been installed in the dementia wing (residents’ bedrooms, communal areas and bathrooms). Call bell alarms are regularly tested. These are improvements from the previous (partial provisional) audit. |
| 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 and is described in the infection prevention and control policy. The clinical coordinator is the designated infection control nurse. Short-term care plans are used. Surveillance of all infections are entered onto a monthly facility infection summary and staff are informed. This data is monitored and evaluated monthly and annually. Monthly data is discussed at monthly health and safety/staff and quality meetings. Infection control education has been provided in 2017. There have been two outbreaks since last audit (August 2016 and June 2017) and both were appropriately managed.  Internal audits for infection control are included in the annual audit schedule. There is close liaison with the GP who advises and provides feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has documented systems in place to ensure the use of restraint is actively minimised. Enabler use is voluntary. Staff interviews, and staff education records evidenced education and training has been provided on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Restraint is discussed in the quality meetings. A registered nurse is the designated restraint coordinator. She was not available during the audit.  There were eight residents (hospital level) using restraint (six cot sides and two table top chairs) and three residents (hospital level) with an enabler. All three residents’ files of residents using an enabler were reviewed. (The sample size was expanded to identify any trends). |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Low | Medication | (i) Two expired medications (GTN spray and one box of risperidone tablets) were found on the dementia medication trolley.  (ii) Fridge temperature monitoring record reviewed for the fridge in the medication room did not document fridge temperatures as required. | (i) Ensure all expired medications are discarded appropriately and in a timely manner. (ii) Ensure fridge temperatures are documented as required for any fridge containing medicines.  90 days |
| Criterion 1.4.2.6  Consumers are provided with safe and accessible external areas that meet their needs. | PA Low | In the dementia unit, there are two exits to a secure outdoor area. Access to this area requires key pad entry. During an interview with one HCA, it was confirmed that staff frequently need to open doors for residents to allow them to walk outside. | Both doors leading to a secure outdoor area in the dementia unit require key pad entry to open the doors. | Ensure that dementia level residents are freely allowed to go outdoors into a secure environment.  90 days |

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

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

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

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

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| No data to display |

End of the report.