

Lakeside Lodge Rest Home Limited - Lakeside Retirement Lodge

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:	Lakeside Lodge Rest Home Limited
Premises audited:	Lakeside Retirement Lodge
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 26 September 2017 End date: 26 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:	28

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

Lakeside Retirement Lodge provides rest home levels of care for up to 30 residents and on the day of the audit there were 28 residents. The service is managed by an owner/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 resident and staff files, observations and interviews with residents, family members, staff and management.

The service has addressed the two shortfalls from their previous audit around completing interRAI assessments in a timely manner and medication documentation.

This surveillance audit identified that improvements are required around adverse events for suspected head injuries, human resource process, documenting interventions to reflect the residents' current needs and medication management.

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.		Standards applicable to this service fully attained.
--	--	--

Families interviewed reported that they are kept informed. A system for managing complaints is in place. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

Organisational management

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

The service is owned by an owner/manager who is supported by a clinical manager/registered nurse. Services are planned, coordinated and are appropriate to the needs of the residents. Quality and risk management processes are established and implemented. Quality goals are documented and regularly reviewed. A risk management programme is in place, which includes incident and accident reporting, and health and safety processes.

An orientation programme is in place for new staff. A staff education and training programme is being implemented. Registered nursing cover is available either on-site four days a week, or on-call twenty-four hours a day, seven days a week. There are adequate numbers of staff 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>
---	--	---

The clinical manager/registered nurse (RN) is responsible for each stage of service provision. The clinical manager assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration. Resident files included medical notes by the contracted GP and visiting allied health professionals. 1

The activities coordinator provides an activities programme for the residents that is meaningful, varied, interesting and involves the families/whānau and community.

Medication policies comply with legislative requirements and guidelines. Staff responsible for administration of medicines complete education and medication competencies.

All meals are prepared on-site. Food, fridge and freezer temperatures are recorded. Individual and special dietary needs are catered for. Residents, family/whānau interviewed responded favourably to the food that was provided.

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.
--	--	--

There is a current building warrant of fitness (expires 31 May 2018).

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.
---	--	--

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. No restraints or enablers were in use.

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.
---	--	--

The infection control surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

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	13	0	3	1	0	0
Criteria	0	35	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)
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>	FA	<p>The complaints procedure is provided to residents and families during entry to the service. Complaints forms are readily available in an accessible location. A record of complaints received is able to be maintained using a complaint's register. No complaints have been received since 2011.</p> <p>Discussions with six rest home level residents and families confirmed they were provided with information on the complaints process and remarked that any concerns or issues they had were addressed promptly.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed at all times. The managers (owner/manager/RN and clinical manager/RN) and care staff interviewed (two caregivers, one activities coordinator) understood the importance of open disclosure and providing appropriate information and resource material when required. During the audit evidence was sighted of family being contacted following an adverse event.</p> <p>Three family members interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Fifteen accident/incident forms reviewed reflected documented evidence of</p>

<p>conducive to effective communication.</p>		<p>families being informed following an adverse event.</p> <p>An interpreter service is available and accessible if required through the district health board. Families and staff are utilised in the first instance.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Lakeside Retirement Lodge provides care for up to 30 rest home level residents. On the day of audit there were 28 residents. All residents were being provided with services under the aged residential care agreement.</p> <p>The owner/manager is a registered nurse with a background in mental health. He has worked in aged care since 1996 and has owned Lakeside Retirement Lodge for over 13 years. His wife, who also is a registered nurse, is the clinical manager. They both hold current practising certificates.</p> <p>The philosophy, mission, scope and goals of the service are documented in the quality manual and in the information pack that is provided to residents and their families during their admission to the rest home. Goals are regularly reviewed by the management team.</p> <p>The manager has maintained at least eight hours annually of professional development activities related to managing a rest home. He regularly attends aged care meetings. The manager and the clinical manager have both completed their interRAI training.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>A quality and risk management system is established that is understood by staff, as confirmed during interviews with the managers (owner/manager and clinical manager) and staff (two caregivers, one activities coordinator, one cook). Policies and procedures have been developed by an external consultant. They reflect evidence of reviews in 2017. New policies and updates to existing policies are discussed in staff meetings as evidenced in the monthly staff meeting minutes.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, maintenance issues, infection control data collection and complaints management. Data is collected and analysed each month. Results are shared with staff in staff meetings and are posted in a visible location for staff to read (e.g., number of falls, infections). The internal audit programme reviewed (April – June 2017 and July – September 2017) reflected full compliance with no areas identified for improvements. The corrective action process being implemented addresses maintenance issues. An example of a quality initiative for 2017 has been the installation of a new call bell system.</p> <p>Health and safety policies have recently been reviewed and meet current legislative requirements. A health and safety officer has been appointed but was not available on the day of the audit. Staff receive health and safety training, which begins during their induction to the service. All staff are involved in health and safety, which is a regular topic in the monthly staff meetings. Specific health and safety meetings are conducted monthly. Attendance includes the health and safety officer and the manager. Actual and potential risks are documented on the hazard</p>

		<p>register, which identifies risks and documents actions to eliminate or minimise the risks. This internal review was last completed on 12 May 2017.</p> <p>Falls management strategies include the development of specific falls management plans to meet the needs of each resident who is at risk of falling (link 1.3.6.1).</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>	PA Low	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Incident/accident data is linked to the organisation's quality and risk management programme. Fifteen accident/incident forms were reviewed. Unwitnessed falls that may have a head injury are documented by the RN as 'observed' with no further details provided. Each event involving a resident reflected follow-up by either the manager/RN or the clinical manager/RN.</p> <p>The manager is aware of his responsibility to notify relevant authorities in relation to essential notifications with examples provided.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies in place to support good employment practices. The manager, clinical manager and staff registered nurse practising certificates are current. Five staff files were reviewed (one RN, two domestic staff, two caregivers) had relevant documentation relating to employment. There are job descriptions in place although documented evidence to support employees being given copies of job descriptions was not sighted. There was no documented evidence to support the completion of reference checking potential applicants.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Caregivers interviewed were able to describe the orientation process and believed they were adequately orientated to the service. An education programme is in place and training occurs at least monthly. Caregivers administering medications are assessed as competent by a registered nurse. Staff performance appraisals are completed annually.</p> <p>There is a first aid trained staff member on-site at all times during the am and pm shifts but not consistently during the night shifts. The activities coordinator also has a current first aid certificate. Two of three RNs have completed their interRAI training.</p>

<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>A roster policy is in place to ensure there are sufficient staff on duty to meet the health and personal needs of all residents at all times. An RN is either on-site or on-call 24 hours a day, seven days a week.</p> <p>The manager and his wife are both RNs. The manager is on-site five days a week (Monday – Friday) and is on call when not available on-site. The clinical manager is available four days a week (Monday/Tuesday and Thursday/Friday). A staff RN is on duty three days a week covering every Wednesday and two weekends on, followed by one weekend off. She covers both am and pm shifts. This RN also covers in the absence of the manager and the clinical manager.</p> <p>There are two caregivers rostered on the morning (AM) shift Monday – Friday and three caregivers over the weekend. Two caregivers are rostered on the afternoon (PM) shift and two caregivers are rostered on the night shift. Caregivers assist with laundry duties. There are separate cleaning staff Monday – Friday (9am-3pm) and a part-time activities coordinator is employed Monday – Friday from 8.45am to 12.00noon.</p> <p>Staff reported that staffing is increased if the resident acuity increases. The manager reported that there has been no reduction in staffing since the pay equity issue has come into effect. He plans to review the financial viability of the service in early 2018.</p> <p>Interviews with residents and relatives confirmed that staffing is adequate to meet the needs of the residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management (including self-medication) that meet legislative requirements. The facility uses a blister pack medication system. Medicines are reconciled fortnightly by an RN upon delivery. Ten medication charts were reviewed. All senior staff who administer medications had been assessed for competency on an annual basis. Education around safe medication administration has been provided. The medication round observed at lunchtime identified issues with the safety of administering medications. Staff interviewed could describe their role in regard to medicine administration. Standing orders are not used. There were no residents self-medicating on the day of audit.</p> <p>Controlled drug checks are maintained weekly by the RN and at least six-monthly by pharmacy (last in June 2017). The medication fridge temperatures are recorded regularly and these are within acceptable ranges. Expired medications were located in the imprest cupboard.</p> <p>All medication charts sampled had been documented correctly by the GP and this is an improvement on previous audit. The medication charts reviewed identified that the GP had seen and reviewed the resident three-monthly. Review of signing sheets evidenced administration and signing errors had occurred.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The facility employs four staff (two cooks and two kitchen assistants) who cover seven days per week. The main cook oversees food provision. Both cooks had completed training in food safety and chemical safety. All meals at Lakeside retirement lodge are prepared and cooked on-site. There is a four-weekly seasonal menu, which had been reviewed by a dietitian (last February 2016). Meals are delivered to the dining area adjacent to the kitchen. Dietary needs are known with individual likes and dislikes accommodated. Pureed, gluten free, diabetic desserts are provided. Cultural and religious food preferences are met. Supplements are provided to residents with identified weight loss issues.</p> <p>Fridge, freezer and chiller temperatures are taken and recorded daily. End cooked food temperatures are recorded daily. Food stored in the fridge had been labelled and dated.</p> <p>Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>Five resident care plans were reviewed. Interventions to guide care were not always documented to reflect current resident needs or updated to reflect a change in health condition. Long-term care plans were in place for all resident files sampled and were reviewed six-monthly. Caregivers interviewed were knowledgeable about the resident's current 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>	<p>FA</p>	<p>Staff (RN and caregivers) follow the care plan and report progress against the care plan at each shift handover. If external nursing or allied health advice is required, the RN will initiate a referral (eg, to the district nurse, dietitian, physiotherapist). If external medical advice is required, this will be actioned by the GP. Staff have access to sufficient medical supplies (eg, dressings). Sufficient continence products are available and resident files include a continence assessment and plan as part of the plan of care. Specialist continence advice is available as needed and this could be described.</p> <p>Wound management plans were fully documented for all current wounds. There were no pressure injuries on the day of audit. All wounds have been reviewed in appropriate timeframes. The RN interviewed described access to specialist nursing wound care management advice through the district nursing service or DHB wound nurse specialist.</p> <p>Interviews with the registered nurse and caregivers demonstrated an understanding of the individualised needs of residents. Care plan interventions did not always document the interventions in sufficient detail to guide the care</p>

		staff (link# 1.3.5.2). There was evidence of regular monitoring such as; food and fluids, blood glucose, pain, bowels and weight (monthly or more frequently if required) management. Progress notes documented fluid intake, effectiveness of pain relief given, regular toileting and hygiene cares.
<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>	FA	<p>An activities coordinator (AC) works 20 hours per week and coordinates and delivers the programme 8.45am to 12.00pm Monday to Friday. A volunteer assists with the programme, attends seven days a week and has done this for more than twelve years. The activities programme provides individual and group activities that are meaningful and reflect ordinary patterns of life. The monthly programme includes craft, van outings (includes farm visits, visits to Mercer Museum), church services, games, gardening and a daily exercise programme. Residents attend groups (bowls, cosmopolitan club) in the local community. Residents and staff prepare and celebrate theme days (costume is worn and themed food and entertainment is provided), kapa haka visit. On the day of audit, residents were observed actively participating in a variety of activities. Once a week, residents put forward ideas for activities they would like included for the following week. The AC brings in antiques (Morse code machine) to encourage reminiscing. Two residents who previously did not participate, now participate in some activities. One-on-one activities are provided for residents who are unable or choose not to be involved in group activities.</p> <p>The AC is responsible for the resident's individual recreational and lifestyle plans, which are developed within the first three weeks of admission. The resident/family/whānau, as appropriate, are involved in the development of the activity plan. Resident files reviewed identified that the individual activity plan is reviewed six-monthly.</p> <p>Residents provide feedback and suggestions for activities individually, or at the resident meetings and via the annual resident satisfaction survey.</p> <p>Residents and families interviewed report satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>The registered nurse evaluates all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plan were documented and evaluated at least six monthly. Not all LTCPs had been updated when there was a change in health status (link 1.3.5.2). There was at least a three monthly review by the GP. Re-assessments have been completed using InterRAI LTCF for all residents who have had a significant change in health status since 1 July 2015. Overall, short-term care plans sighted were evaluated and resolved and added to the long-term care plan where the problem was ongoing.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are</p>	FA	<p>A current building warrant of fitness is posted in a visible location (expiry 31 May 2018).</p>

provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		
<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>	FA	<p>Systems are in place and are appropriate to the size and complexity of the facility. Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly to identify areas for improvement or corrective action requirements. The facility manager (RN) and/or clinical manager and GP review any resident suspected of having an infection. Specimens are taken where appropriate and sent to the laboratory and a record is maintained in the resident file. A record of all infections is maintained. Infection rates have been low. Trends are identified and quality initiatives are discussed at monthly staff meetings. Infection control internal audits have been completed. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies around restraint, enablers and the management of challenging behaviours. No residents were using either a restraint or an enabler. The clinical manager is the restraint coordinator. Restraint minimisation is a regular agenda item at staff meetings. Staff receive training around restraint minimisation and safe practice.</p>

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 1.2.4.3</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	<p>Unwitnessed falls that may have a head injury are documented by the RN as ‘observed’ with no further details provided. Each event involving a resident reflected follow-up by either the manager/RN or the clinical manager/RN.</p> <p>Unwitnessed falls that may have a head injury are documented by the RN as ‘observed’ with no further details provided.</p>	<p>Six of fifteen unwitnessed falls did not reflect evidence of neurological observations/vital signs. The RN documented ‘observed’ only.</p>	<p>Ensure neurological observations are completed for any suspected injury to the head.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate</p>	PA Low	<p>Five staff files reviewed contained evidence of an interview but did not include reference checking. The manager reported that job</p>	<p>There was no documented evidence to indicate that reference checking is completed before staff</p>	<p>Ensure there is documented</p>

service providers to safely meet the needs of consumers.		descriptions are handed to new employees.	are employed.	evidence of reference checking being completed for potential applicants. 90 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The am and pm shifts are covered by a minimum of one staff who holds a first aid/CPR certificate but the night shift is not consistently covered.	Two, of four nightshifts indicated that there are no staff available who hold a current first aid/CPR certificate.	Ensure that there is a minimum of one staff available at all times who holds a current first aid/CPR certificate. 90 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>	PA Moderate	Senior staff with current medication competencies administer medicines. The lunchtime medication round was observed. The medications were reviewed against the medication chart prior to administration, however, shortfalls were identified with administration of medicines. Expired medications were sited in the imprest cupboard.	<p>The following shortfalls with medications were identified;</p> <p>(i) On three occasions medications were left with the resident and not observed to be swallowed by the resident.</p> <p>(ii) On three occasions medication was signed for prior to administration.</p> <p>(iii) Five expired medications were found in the imprest cupboard.</p> <p>(iv) One resident file (tracer) had</p>	<p>(i-ii) Ensure all medication is administered as per medication legislation and guidelines.</p> <p>(iii) Ensure expired medications are discarded</p>

			<p>medications signed for at dinner and supper time on several dates, however, medications were no longer charted</p>	<p>in a safe manner.</p> <p>(iv) Ensure only charted medications are signed as given</p> <p>30 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Low</p>	<p>InterRAI assessment informs long-term care plans. Not all care plans reviewed documented interventions to reflect current resident needs.</p>	<p>Four of five resident files reviewed did not document interventions to reflect current changes in care needs or current assessed needs for, however caregivers interviewed could describe current cares for each of the files reviewed.;</p> <p>i) a resident with high falls risk had no documented falls prevention measures</p> <p>ii) a resident with recurrent UTI had interventions to support management of the UTI</p> <p>iii) a resident with diabetes on insulin had no documented interventions to manage hypo/hyperglycaemia</p> <p>iv) a resident with epilepsy and paranoid behaviour had no interventions re: management of seizure presentations or behaviour management to include de-escalation/distraction</p>	<p>(i-iv) Ensure interventions are documented for all current needs including changes in health status</p> <p>90 days</p>

			techniques	
--	--	--	------------	--

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.