

Komal Holdings Limited - Bloomfield Court Retirement Home

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: Komal Holdings Limited

Premises audited: Bloomfield Court Retirement Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 4 December 2017 End date: 5 December 2017

Proposed changes to current services (if any): The service has increased rest home bed numbers by one bedroom to 27 beds

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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

Bloomfield Court rest home provides rest home level care for up to 26 residents and has a current occupancy of 24.

This unannounced surveillance audit was conducted against a subset of the Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, staff, management and the general practitioner. This audit also assessed one additional room as being suitable to provide rest home level care

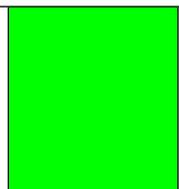
Staff turnover is reported as low. Staff interviewed, and documentation reviewed identified the quality and risk management systems in place are appropriate to meet the needs and interests of the resident group. Family and residents interviewed all spoke very positively about the care and support provided.

The service is privately owned and is managed by a registered nurse who has worked intermittently at Bloomfield for fifteen years. The manager has been in her current role for six months. She is supported by two part-time registered nurses and care staff.

The service has addressed five of the six previous findings relating to: quality data analysis and communication, use of correctional fluid, the assessment process, kitchen training, food, fridge and hot water temperatures.

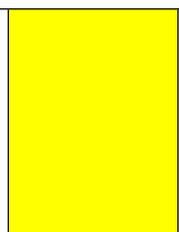
Further improvements are required around interRAI assessment timeframes. This audit identified that improvements are required around completing health and safety management and medication administration.

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.
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Residents receive a high standard of support and assistance, staff communicate effectively with the residents. Residents and their families are kept informed, and there is documentation to evidence communication with families. Residents and their families are aware of how to make a complaint and their right to do so. The complaints process ensures issues are managed in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Bloomfield Court has an organisational philosophy, which includes a vision, mission statement and strategic objectives. The owner has owned the facility for the past two and a half years. The manager is supported in her role by two part-time registered nurses and care staff. The facility is guided by a comprehensive set of policies and procedures which are reviewed. An internal audit programme monitors service performance. Where performance is less than expected, a corrective action process is implemented. Health and safety policies, systems and processes are implemented to manage risk. Adverse events are effectively managed. Human resources processes are managed in accordance with good employment practice, meeting legislative

requirements. The induction and education and training programmes for the staff ensure staff are competent to provide care. Staffing levels are safe and appropriate.

Continuum of service delivery

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.
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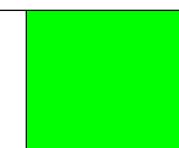
Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. There are entry and admission procedures in place. Residents and family members interviewed state that they are kept involved and informed about the resident's care. Care plans are developed by the registered nurse who also has the responsibility for maintaining and reviewing care plans. Care plans are individually developed with the resident, and family/whānau involvement is included where appropriate and evaluated six monthly or more frequently when clinically indicated. Risk assessment tools and monitoring forms are available to assess effectively the level of risk and support required for residents. A range of activities are available, and residents provide feedback on the programme. The medication management system includes medication policy and procedures that follows recognised standards. The service has food policies/procedures for food services and menu planning appropriate for this type of service. Dietitian input is obtained. Residents' food preferences are identified, and this includes any dietary preferences or needs.

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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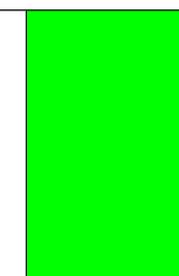
Bloomfield Court has a current building certificate which expires on 1 June 2018.

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.
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The use of restraint is actively minimised. Restraint is regarded as the last intervention when no appropriate clinical interventions, such as de-escalation techniques, have been successful. On the day of audit, there were no residents assessed as requiring restraint or enablers. Staff are required to attend restraint minimisation and safe practice education. The restraint minimisation programme is reviewed through the quality management system.

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 registered nurse is the infection control coordinator. 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. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

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	0	0	0
Criteria	0	36	0	3	0	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>A complaints policy and procedures are in place. The manager is responsible for ensuring complaints are addressed within the required timeframe and maintains contact with the complainant throughout the complaints process. A complaints procedure is provided to residents within the information pack at entry. Four complaints received in 2016 and one complaint from 2017 were reviewed and reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Documentation including follow-up letters and resolution demonstrates that complaints are being managed in accordance with guidelines set forth by the Health and Disability Commissioner timeframes. Residents and family members interviewed advised that they are aware of the complaints procedure.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The registered nurse welcomes residents and families on entry and explains about services and procedures. Six residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Evidence of communication with family/whānau is recorded on the ten accident/incident form and in the residents' progress notes. Accident/incident forms reviewed identified family had been kept informed. Three relatives interviewed stated that they were informed when their family member's health status changed.</p>

conducive to effective communication.		
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Bloomfield Court is a 27-bed rest home (one bedroom has been built on since previous audit. This room has been verified at this audit as suitable to provide rest home level care). On the day of audit there were 24 rest home residents. All residents are under the ARCC agreement. The owner/manager purchased the business in June 2015. The owner closely supports the manager who has the responsibility of the daily operations, and oversees the delivery of services. The manager is supported by two part-time registered nurses (RNs).</p> <p>There is a business plan for 2015-2017 in place. Goals identified included (but not limited to): upgrade the accommodation and environment, and provide quality training in the areas of care services. There have been environmental improvements and purchase of new equipment. The refurbishing plan is ongoing. Staff interviewed confirmed the communication levels are good and the staff work together as a team. Residents and families speak highly of the staff and the services provided.</p> <p>The Bloomfield Court manager has attended at least eight hours of training relating to the management role. The manager with the support of the owner is available on call for any facility or staffing matters.</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>	PA Low	<p>Interviews with the manager, clinical nurse manager and staff (two caregivers, one registered nurse, one recreational officer and one cook) reflect their understanding of the quality and risk management system. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies and procedures are stored in hard copy at the facility. An external provider provides updates and reviews with the manager conducting further reviews to ensure that each policy aligns with the service. New policies or changes to policy are communicated to staff.</p> <p>The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) accidents and incidents, infections, complaints, pressure areas, restraint (of which there is none) and medication errors. Paper-based data is collected and entered into an online system which provides reports graphs and trends. The data is then benchmarked against other similar facilities. Fall prevention strategies are in place that include the analysis of fall incidents and the identification of interventions on a case-by-case basis to minimise future falls. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented when required and are signed off by the manager or clinical nurse manager when completed. A daily summary is emailed to the owner.</p> <p>Quality and risk data, including data trends are discussed in two monthly staff and monthly quality meetings. Minutes for all meetings have included actions to achieve compliance where relevant. Resident/relative meetings have been held two monthly.</p>

		<p>The resident/relative survey conducted in September 2017 attracted eleven respondents. Comments were very positive with residents stating they were overall very satisfied. Survey outcomes are communicated to residents via the residents meeting. Residents/families were surveyed around first impressions, grounds and environment, staff, activities, food and general care.</p> <p>There is a health and safety and risk management system in place including policies to guide practice. Shortfalls have been identified regarding health and safety training and hazard identification implementation.</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>	FA	<p>Incident and accident data is collected. Discussions with the service confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. A sample of 10 resident related incident reports were reviewed. All reports and corresponding resident files reviewed evidence that appropriate clinical care has been provided following an incident. The incident reporting policy includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Monthly and annual reviews of incidents inform quality initiatives.</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>	FA	<p>The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Five staff files were reviewed (the activities coordinator, the cook, a registered nurse and two caregivers) and included all appropriate documentation. Staff turnover was reported as low, with some staff having been employed more than 15 years.</p> <p>The service has a comprehensive orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. The registered nurses and caregivers attend external training including seminars and education sessions with the local DHB. Caregivers have completed either the national certificate in care of the elderly or are working towards completion. Education is provided either as face-to-face sessions, self-directed reading and learning or attendance at in-service sessions. The registered nurse has completed interRAI training. Attendance rates are recorded and indicate good levels of attendance by staff. The completed in-service calendar for 2017 exceeds eight hours annually, however, did not</p>

		include health and safety (link 1.2.3.9).
<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>	FA	<p>Bloomfield Court has a weekly roster in place, which provides sufficient staffing cover for the provision of care and service to residents. There is a registered nurse on duty or on call at all times. There is a registered nurse on-site five days per week. There are at least two caregivers on each morning and afternoon shift with one caregiver rostered at night. Caregivers, residents and family interviewed advised that sufficient staff are rostered on for each shift. There is at least one staff member trained in first aid and CPR on duty at all times. Care staff interviewed advised that they are well supported by the manager and registered nurses. One general practitioner was interviewed who confirmed that staffing is appropriate to meet the needs of residents. Four residents and three relatives confirm that there are sufficient staff on duty, and that they are approachable, competent and friendly.</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>	PA Low	<p>There are comprehensive medication management policies and procedures in place. The service uses individualised blister packs that are checked-in on delivery by a registered nurse. A caregiver was observed administering medications correctly. Medications and associated documentation were stored safely and securely. Eye drops currently being used are dated on opening as sighted. There are no standing orders. Weekly and pharmacy six-monthly controlled drug stocktakes were recorded. Medications are reviewed three monthly with medical reviews by the attending GP. Resident photos and documented allergies or nil known were on all 10 medication charts reviewed. An annual medication administration competency is completed for all staff administering medications and medication training had been conducted.</p> <p>There is a self-medicating residents' policy and procedures in place. One resident self-administers inhalers only. Three monthly resident competency assessments signed by the GP are evidence to confirm the resident's ongoing ability to safely self-medicate. Individually prescribed resident medication charts are in use and this provides a record of medication administration information. All medication charts reviewed recorded accurate indications for use of 'as required' medication by the GP. Not all medication administration records sampled documented all prescribed medication being administered.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids</p>	FA	<p>All meals at the service are prepared and cooked on-site. There is a four-weekly winter and summer menu, which has been reviewed by a dietitian. Meals are prepared in a well-appointed kitchen and served to the residents in the adjoining dining room. Kitchen staff are trained in safe food handling and food safety procedures are adhered to. The service records all fridge and freezer temperatures. Fridge and freezer temperatures and prepared food temperatures are documented. Staff were observed serving and assisting residents with their lunchtime meals and drinks. Diets are modified as required. Food services staff know resident dietary profiles, and likes and dislikes and</p>

<p>and nutritional needs are met where this service is a component of service delivery.</p>		<p>any changes are communicated to the kitchen via the registered nurses. Supplements are provided to residents with identified weight loss issues. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Residents and the family members interviewed were very happy with the quality and variety of food served.</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>Caregivers follow the care plan and report progress against the care plan each shift. If external nursing or allied health advice is required the RNs will initiate a referral (eg, to the district nurse). 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. Specialist continence advice is available as needed and this could be described. Monitoring forms sighted were in place for, behaviour management, fluid balance charts, blood glucose and pain management.</p> <p>Wound assessment and a wound management plan is in place for five residents with nine wounds. One resident had five chronic skin lesions. Other wounds included a skin tear, surgical site, and two inflamed toes. All wounds evidence assessment, a management plan and regular evaluations. The registered nurse interviewed described the referral process and related form should they require assistance from a wound specialist or continence nurse. Care plans are goal oriented and reviewed at least six monthly by a registered nurse.</p> <p>The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, three caregivers and one registered nurse. A review of short-term care plans, long-term care plans, evaluations and progress notes demonstrate integration.</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 works 27.5 hours per week over five days and as required, providing an activities programme with support from external providers and other staff. The activities coordinator meets monthly with other activities coordinators in the area. The programme is planned monthly. Activities planned for the day are displayed on noticeboards around the facility. An activity plan is developed for each individual resident based on assessed needs as part of the care plan. One of three activity plans (two residents had not been at the service for six months) were reviewed six monthly (link 1.3.3.3). Residents are encouraged to join in activities that are appropriate and meaningful and are encouraged to participate in community activities.</p> <p>There is a wide range of activities offered, that reflects the resident needs including but not limited to: newspaper reading, communion, church services, exercises, visiting entertainment, seasonal celebrations, music, quizzes, craft, games, happy hour, van outings, indoor sports, shopping, movies, and crosswords. Residents were observed participating in activities on the day of audit. There is a copy of the monthly and weekly programme posted on the noticeboard. Three monthly resident meetings provided a forum for feedback relating to activities. The activities coordinator runs the meetings and encourages residents input into the programme including choice of outings and crafts. Residents and family members interviewed discussed enjoyment in the programme and the diversity offered</p>

		to all residents.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans reviewed were updated as changes were noted in care requirements. Care plan evaluations were comprehensive documented and related to each aspect of the care plan and recorded the degree of achievement of goals and interventions. Care plans were evaluated within the required timeframes. Short-term care plans are utilised for residents and any changes to the long-term care plan were dated and signed. Examples of STCPs in use include; infections, weight issues and wounds. .</p> <p>Staff are informed of any changes to resident need at handover between shifts. Caregivers interviewed confirmed that they are updated as to any changes to/or in resident's care or treatment during handover sessions, which occur at the beginning of each shift.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The service displays a current building warrant of fitness which expires on 1 June 2018. The service has a disaster plan which includes specific emergencies. Staff received emergency training in June 2017. The previous partial attainment related to hot water temperatures has been addressed. As part of this audit, an additional room was reviewed and is suitable for the provision of rest home level care.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in Bloomfield Court's infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Surveillance of all infections are entered onto a cloud-based monthly infection summary. This data is monitored and evaluated monthly and annually and benchmarked against other similar facilities. Outcomes and actions are discussed at the general staff meetings which incorporates infection control. If there is an emergent issue, it is acted upon in a timely manner. Full records including management and timeline of events relating to a Norovirus outbreak from August 2017 were reviewed. Details relating to residents and staff who contracted the illness were tracked and monitored and a debriefing meeting was held with staff to review the outbreak management.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Bloomfield Court is committed to restraint minimisation and safe practice as evidenced in the restraint policy and interviews with staff. Policy states that enablers are voluntary. There are no residents using enablers and no residents assessed as requiring restraint. Policy includes guidelines for use of enablers and restraint, alternatives to be conducted, de-escalation techniques, use of diversional therapies, and used as a last resort. Policy also includes definitions for restraint and enablers.</p> <p>Staff have had training around restraint minimisation in September 2017.</p>
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	Health and safety policies and procedures are in place. These are updated by an external consultant and reflect changes to the Health and Safety at Work Act. Health and safety policies and the hazard manual folders are readily available for staff to view. Hazard forms are developed. The orientation programme includes health and safety training.	<p>i) The hazard manual does not evidence that risks associated with the service have been identified or documented.</p> <p>ii) Education records do not evidence staff have</p>	<p>i) Ensure the documented process for hazard identification is implemented.</p> <p>ii) Ensure staff education includes health and safety training.</p>

			been provided with ongoing health and safety training	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 Low	<p>There are comprehensive medication management policies and procedures in place. Medications are managed appropriately in line with accepted guidelines.</p> <p>The service uses a monthly medico blister pack medication system for all residents at Bloomfield Court Retirement Home. The medication trolley and medication folder are stored in a locked medication/treatment room. One senior caregiver was observed safely administering medications - checking the medication chart, the medico pack and then observing the resident taking the medication and completing documentation. Staff sign for the administration of medications on medication sheets held with the medicines. Not all signing sheets had been completed fully.</p>	Three of 10 medication signing sheets included signing gaps	<p>Ensure all medications are administered as per medication charts and signed when given.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Care plans are developed by the service's registered nurse (RN) who also has the responsibility for maintaining and reviewing care plans. An initial assessment and care plan is completed on admission. InterRAI assessments have been completed for all residents, however not all within contractual timeframes. The long-term care plans reviewed were developed within three weeks. Care plans are developed in consultation with other relevant people including residents and where appropriate family/whānau. There is evidence of other allied health services input at the admission process (ie, general practitioner (GP), physiotherapy, dietitian, occupational therapist and podiatry). Activity assessments and the activities care plans are completed by the activities</p>	(i)Two of three residents' activity care plans were not reviewed within six months.: (ii) Four of five initial interRAI assessments were not completed	<p>Ensure that all activity assessments and care plans are developed in a timely manner.</p> <p>90 days</p>

		coordinator.	within contractual timeframes.	
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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.