

# Summerset Care Limited - Summerset in the Bay

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## 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:** Summerset Care Limited

**Premises audited:** Summerset in the Bay

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

**Dates of audit:** Start date: 23 May 2018 End date: 23 May 2018

**Proposed changes to current services (if any):** One renovated extra room was assessed as suitable as a respite room (previous salon). The service has documented processes around how this will be managed.

**Total beds occupied across all premises included in the audit on the first day of the audit: 55**



# Executive summary of the audit

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## Introduction

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

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

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

## Key to the indicators

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

<b>Indicator</b>	<b>Description</b>	<b>Definition</b>
	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

Summerset in the Bay provides rest home and hospital level care for up to 58 residents. On the day of the audit there were 55 residents in total. The village manager is appropriately qualified and experienced and is supported by a care centre manager (registered nurse) who oversees the care centre. The residents and relative interviewed spoke positively about the care and support provided.

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, family member, staff and management. This audit also included verifying one new resident room as suitable for respite (was previously a salon before renovation) including emergency respite for village residents as required. The service has documented processes around how this will be managed. This will increase overall bed numbers to 59 beds (including 10 certified serviced apartments).

This audit identified two improvements required around annual performance appraisals and medication chart reviews.

## 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.

Residents and family are well informed including of changes in resident's health. Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

## 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 quality and risk management programme includes service philosophy, goals and a quality planner. Quality activities are conducted, and this generates improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Resident/family meetings held monthly. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2018 is in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## 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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The registered nurses are responsible for each stage of provision of care. Assessments, care plans, and evaluations were completed by the clinical nurse leader and registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care. A diversional therapist and activity coordinator implement an integrated activity programme. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers. There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education.

The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

## Safe and appropriate environment

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

## **Restraint minimisation and safe practice**

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there were five residents with restraints and two residents using an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours.

## **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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The infection control officer uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities. There have been no outbreaks.

## 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	14	0	2	0	0	0
Criteria	0	39	0	2	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

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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
Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. There is a complaint register that included relevant information regarding the complaint. The number of complaints received each month is reported monthly to staff via the various meetings. There were six complaints received in 2017 (one complaint was made through the Health and Disability Advocacy) and one complaint made in 2018 year-to-date. All of the complaints documentation included follow-up, and resolutions were completed within the required timeframes. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment	FA	Six residents, including three hospital and three rest home (one in the serviced apartments) interviewed, confirmed they were given an explanation about the services and procedures and that their cultural needs are being met. Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Ten incidents/accident forms reviewed include a section to record family notification. All forms evidenced family were informed or if family did not wish to be informed. One relative (hospital) interviewed confirmed that they are notified of any changes in their family member's health status. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.

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>The service provides care for up to 58 residents at hospital and rest home level care. There are 48 dual-purpose beds in the care centre on level one and 10 serviced apartments on the ground floor certified to provide rest home level care. On the day of the audit there were 55 residents in total, 17 residents at rest home level including two residents on respite care and 31 hospital level residents including two younger persons on long-term support chronic health condition (LTS-CHC) contracts and one resident on an ACC funded contract. There were seven rest home level residents in the serviced apartments. All other residents were under the aged residential related care (ARRC) contract.</p> <p>This audit also included verifying one new resident room as suitable for emergency respite for village residents as required (the renovated room was previously a salon). The service has documented processes around how this will be managed. This will increase overall bed numbers to 59 beds.</p> <p>The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset in the Bay has a site-specific business plan and goals that is developed in consultation with the village manager, care centre manager and regional operations manager. The 2018 business plan was in place. There is a full evaluation at the end of the year. The 2017 evaluation was sighted.</p> <p>The village manager has been in the role at Summerset since May 2015 and has been with Summerset for six years. The village manager is supported by a care centre manager and a clinical nurse leader. The care centre manager has been in the position since January 2017 and has considerable clinical management background in the aged care industry. The clinical nurse leader has been in the role since February 2018. There is a regional operations manager and regional quality manager (present on the day of the audit) who are available to support the facility and staff.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and</p>	FA	<p>There is a documented Summerset organisation's quality and risk management system. The content of the policies and procedures is detailed to allow effective implementation by staff. The service's policies are reviewed at an organisational level. The quality and risk management system is designed to monitor contractual and standards compliance. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the village manager completes a 'best practice' sheet confirming completion of these requirements. The best practice sheet reports (but not limited to): meetings held, induction/orientation, audits, competencies and projects. This is forwarded to head office as part of the</p>

<p>maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>ongoing monitoring programme.</p> <p>The service is implementing an internal audit programme for 2018 that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home, hospital and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in September 2017 was at 96%. Corrective actions have been established and completed in areas where improvements were identified, (i.e., around personal care, meals and activities).</p> <p>Summerset's clinical quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. Summerset has a data tool "Sway- the Summerset Way". Sway is integrated and accommodates the data entered. There is a health and safety and risk management programme in place including policies to guide practice. The village manager is the health and safety leader (interviewed) and has completed the specific health and safety training requirements. Health and safety internal audits are completed. There is a meeting schedule including monthly quality improvement and staff meetings that includes discussion about clinical indicators (e.g., incident trends, infection rates and health and safety). Registered nurse/clinical meetings are held monthly. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</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 has been collected and analysed. Ten resident related incident reports for April 2018 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. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been three section 31 notifications completed since the last audit for three unstageable pressure injuries, one in August 2017 and two in May 2018.</p>

<p><b>Standard 1.2.7:</b> Human Resource Management  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 to support recruitment practices. Five staff files reviewed, including one care centre manager, clinical nurse leader, one registered nurse (RN) and two caregivers evidenced employment contracts and completed orientation. However, performance appraisals have not always been completed annually. A register of registered nursing staff and other health practitioner practising certificates is maintained. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme includes documented competencies and induction checklists (sighted in files of newly appointed staff). Staff interviewed were able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>There is an annual education plan for 2018 that is outlined on the 'clinical audit, training and compliance calendar'. In 2017, the education plan had been completed and further training had been provided to caregivers around assessments and RNs around care planning and assessments. Core competencies are completed, and a record of completion is maintained on staff files. The service has six RNs and three of the RNs are trained in interRAI. Staff interviewed were aware of the requirement to complete competency training. Caregivers complete an aged care programme.</p>
<p><b>Standard 1.2.8:</b> Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increase in staffing depending on acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. The village manager and care centre manager both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The clinical nurse leader works 40 hours per week from Thursday to Monday. The service provides 24-hour RN cover.</p> <p>In the care centre there were 17 rest home and 31 hospital residents at the time of the audit. The clinical nurse leader works Mon-Fri. There is also one RN and eight caregivers (four long and four short shifts) on duty in the morning shift, one RN and seven caregivers (three long and four short shifts) on duty in the afternoon shift and one RN, and two caregivers (long shift) on duty in the night shift. There were seven rest home residents in the serviced apartments, there is one caregiver on duty in the morning and afternoon shifts and one caregiver on the night shift to provide cover to the rest home residents in the serviced apartments. Five caregivers interviewed confirmed that there is sufficient staff on duty and that staff are replaced.</p>
<p><b>Standard 1.3.12:</b> Medicine Management</p>	PA Low	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The RNs are responsible for the administration of medications within the care centre and serviced apartments. Staff complete annual medication competencies and education. All medications are stored safely in the one main</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>medication room. Robotic rolls are checked on delivery and signed-in on the electronic medication system. There were no self-medicating residents. The medication fridge is monitored at least weekly.</p> <p>Twelve resident medication charts and corresponding medication administration sheets were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications and the effectiveness on the electronic medication system. All as required medications had an indication for use. Not all medication charts had been reviewed by the GP three monthly.</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>	FA	<p>The service has a contracted company since March 2018, for the provision of all meals on-site. There is an eight-week rotating menu that has been reviewed by the dietitian May 2018. The food control plan is in the process of being submitted. The meals are delivered to the care centre dining room in scan boxes (hot and cold) and served from a bain marie by the chef and kitchenhand. Resident likes/dislikes and preferences are known and accommodated with alternative meal options. Texture modified meals, protein drinks and diabetic desserts are provided.</p> <p>The chef receives a dietary profile for each resident. The qualified chef (interviewed), is notified of any changes to resident's dietary requirements/resident preferences. The fridge, freezer and serving temperatures are taken and recorded. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing. Food services staff have completed food safety and hygiene training. Residents have the opportunity to feedback on meals through direct feedback, resident meetings and surveys. Residents interviewed overall were happy with the food service.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. The relative interviewed, stated that their family member's needs are met, and they are kept informed of any health changes. There was documented evidence in the resident files of family notification of any changes to health including infections, accidents/incidents, and medication changes. Residents interviewed, stated their needs are being met.</p> <p>On the day of audit there were four residents (three hospital and one rest home respite) with pressure injuries (two stage two heels, one stage one and one respite resident with two unstageable pressure injuries of the heels on admission). Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for residents with wounds. Photographs and evaluations demonstrate progress towards healing. Chronic wounds are linked to the long-term care plans. There is wound nurse specialist advice and support available at the DHB. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. There are a number of monitoring forms and charts available for use including (but not limited to) pain monitoring, blood sugar levels, weight, wound evaluations, food and fluid</p>

		<p>intake. Short-term care plans describe interventions required to support resident needs for changes to health status.</p>
<p>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.</p>	FA	<p>The service employs a diversional therapist (DT) and activities coordinator to coordinate and implement the Monday to Saturday activity programme. On two days of the week when there are two activity persons on, there is a choice of activities to attend and outings into the community occur at least weekly. The programme is varied, and provides many group and individual activities to meet the hospital and rest home resident's recreational preferences and interests. One-on-one contact is made daily with residents who are unable to or choose not to participate in group activities. Activities include (but are not limited to); exercises and walks, word games and quizzes, news reading, board games, active games, baking, happy hour, art and crafts.</p> <p>There are a number of clubs including knit and stitch, men's club, garden club and walking group. Community visitors/groups include church groups, pre-school children, pet therapy, entertainers and guest speakers. Rest home residents in the serviced apartments can attend either the serviced apartment activities or care centre programme. The younger person's individual recreational needs are met with attending community groups of interest and involvement in meaningful activities within the care centre. Festive occasions and events are celebrated. Two monthly resident meetings and annual surveys provide an opportunity for residents to feedback on the programme. The DT is involved in the multidisciplinary review, which includes the review of the activity plan. Residents interviewed spoke positively about the activity programme.</p>
<p>Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>There is evidence of resident and family involvement in the development and review of long-term resident care plans. All initial care plans of the permanent residents were evaluated by the registered nurses within three weeks of admission. Written evaluations for long-term residents were completed six monthly or earlier for resident health changes against the resident goals (including spiritual and cultural), indicating if goals had been met or unmet. There is evidence of multidisciplinary (MDT) team involvement in the reviews including input from the GP, care staff, DT and any allied health professionals involved in the resident's care. Families are invited to attend the MDT review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN. The GP completes three monthly reviews.</p>
<p>Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate,</p>	FA	<p>The building has a current warrant of fitness. One room was assessed as suitable for respite care including emergency respite for village residents as required (this was originally a hairdressing office). A further renovated room (previous office) was not verified as suitable. The new resident room had an external window with adequate natural light. Communal toilet/shower facilities were located near and a call bell connected to the main call bell system. This was tested and working on the day of audit.</p>

accessible physical environment and facilities that are fit for their purpose.		
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	The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered onto the Sway electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee who meet three monthly. Meeting minutes are displayed for staff. The monthly infection events, trends and analysis are reviewed by management, and data is forwarded to head office for benchmarking. Areas for improvement are identified and corrective actions are developed and followed up. Infection control audits are completed, and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. There have been no outbreaks.
Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers. The service currently has five residents assessed as requiring the use of restraint (bed rails) and two requiring enablers (bed rails). Residents voluntarily request and consent to enabler use. The two resident files using enablers were reviewed and included an assessment and consent for use of an enabler. Staff training has been provided around restraint minimisation and management of challenging behaviours.

## Specific results for criterion where corrective actions are required

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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 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers.	PA Low	There are human resources policies to support recruitment practices. Five staff files reviewed, including one care centre manager, clinical nurse leader, one RN and two caregivers, evidenced employment contracts and completed orientation. However, performance appraisals had not always been completed annually.	Five staff files were reviewed, two of the five files did not have an up-to-date annual performance appraisal.	Ensure that all staff complete an annual performance appraisal.  90 days
Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing,	PA Low	The service uses an electronic medication system. Twelve medication charts were reviewed. Prescribing met the legislative requirements. Ten of twelve medications charts had been reviewed by the	Two of twelve medication charts for two residents with independent GPs, did not have documented	Ensure all medication charts are reviewed three

administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.		contracted GP at least three monthly.	evidence of three monthly reviews.	monthly by the GP.  60 days
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## **Specific results for criterion where a continuous improvement has been recorded**

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

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

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

No data to display

End of the report.