

Radius Residential Care Limited - Radius Thornleigh Park

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:	Radius Residential Care Limited
Premises audited:	Radius Thornleigh Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 May 2018 End date: 30 May 2018
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:	53

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

Thornleigh Park is part of the Radius Residential Care Group. The service provides care for up to 63 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit there were a total of 53 residents.

This 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 the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is a registered nurse (RN) who is experienced in aged care and has been in the role for three years. The manager is supported by a clinical nurse manager who has been in the position for nine months.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

Six of the seven shortfalls identified as part of the previous surveillance audit have been addressed. These were around meetings and follow-up, resident/family input into care, timeliness of interRAI, care plan interventions and monitoring of care. An improvement continues to be required around 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.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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.		Standards applicable to this service fully attained.
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There is a business plan with goals for the service that has been regularly reviewed. The quality system has been implemented. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated six-monthly or more frequently when clinically indicated. There is medication management policies and procedures. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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There is a current building warrant of fitness. Fire evacuations have been undertaken six monthly.

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 service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were no residents using restraints or enablers at the time of the audit.

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 programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	18	0	0	1	0	0
Criteria	0	44	0	0	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 relatives at entry to the service. A paper-based record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register. There have been five complaints for 2018 (YTD). All complaints have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Residents interviewed (two rest home and one hospital) and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Policies and procedures are in place to guide staff on the process around open disclosure. The facility manager and clinical manager confirmed family are kept informed. Relatives interviewed (two hospital and one rest home), stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. The most recent family/resident survey achieved 85% for communication. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised</p>

		resident should they wish to do so. There is access to an interpreter service as required.
<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>Thornleigh Park is part of the Radius Residential Care Group. The service cares for up to 63 residents requiring hospital (geriatric and medical) and rest home level care. There are six dual-purpose beds. On the day of the audit, there were a total of 53 residents, 36 residents receiving rest home level care (including one resident on YPD respite, one YPD, and one long-term support chronic health condition [LTS-CHC] contract). There were 17 residents receiving hospital level care (including one YPD, and one YPD under combined (ACC)/Ministry of Health contract). There are six designated dual-purpose beds.</p> <p>Thornleigh Park continues to work towards its documented business plan that is linked to the Radius Residential Care group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place.</p> <p>Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals and action plans from previous external audits. The facility manager reports monthly to the regional manager on a range of operational matters in relation to Thornleigh Park, including strategic and operational issues, incidents and accidents, complaints, health and safety.</p> <p>The facility manager is a registered nurse (RN) who is experienced in aged care and has been in the role for three years. An experienced clinical nurse manager who has been in the position for nine months supports her. A regional manager supports the facility manager in the management role and was present during the audit. The facility manager and clinical nurse manager have completed in excess of eight hours of professional development in the past 12 months.</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>	FA	<p>Radius Thornleigh is implementing the Radius quality and risk programme. Staff and quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include detailed trend analysis and graphs. Other meetings include; monthly RN and infection control meetings, quarterly health and safety meetings, monthly resident meetings and weekly head of department meetings. Meeting minutes are comprehensive and are reflective of the quality process and plan. Issues are identified, and plans are carried through from meeting to meeting until resolution. This is an improvement on the previous audit.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three healthcare assistants, one registered nurse, one cook, and one activities coordinator) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical</p>

		<p>policies/procedures to support hospital level care.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Shortfalls are identified through audit and corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</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>The service collects incident and accident forms and enters them into an electronic register. The system provides monthly reports, which are discussed at the monthly staff meetings, the monthly RN meetings and the three-monthly health and safety meetings. The service collects all incident data and documents comprehensive trends analysis for a variety of incidents. This has enabled the service to review practice and reduce adverse events.</p> <p>There were twelve incidents documented month-to-date for May; nine falls, two bruises and one aggressive behaviour. Five falls related incidents were reviewed. Neurological observation had been completed as needed, and family informed. Residents care plans and progress notes reflected the incidents and care plans updated as needed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. The healthcare assistants interviewed could describe the incident reporting process. The clinical nurse manager and facility manager collects incident forms, investigates and reviews and implements corrective actions as required.</p> <p>The facility manager interviewed could describe situations that would require reporting to relevant authorities. There have been no reports to the Ministry of Health since their previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in</p>	FA	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one clinical nurse manager, one registered nurse (RN), three healthcare assistants (HCA) and one gardener) include a comprehensive recruitment process which includes: reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained.</p>

<p>accordance with good employment practice and meet the requirements of legislation.</p>		<p>Registered nurses are supported to maintain their professional competency.</p> <p>The orientation programme is position-specific and provides new staff with relevant information for safe work practice. Staff are required to complete written core competencies during their induction. These competencies are repeated annually and were up-to-date. There is an implemented annual education and training plan that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Of the two RN managers and five RNs, two have completed their interRAI training. Advised interRAI-trained RNs is low due to RNs leaving the service to work at the DHB. The service is in the process of booking more RNs into the 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>There is policy in place to determine staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>There is a full-time facility manager (RN) and clinical nurse manager who work from Monday to Friday and provide on call. There is a minimum of one RN on-site at any time. There is one RN on duty in the morning shift, the afternoon shift and the night shift based in the hospital area. The two RN managers also assist with the RN roles to ensure safe coverage.</p> <p>Healthcare assistants; for the AM and for the PM there are five long shifts; two for the hospital (17 residents) and two for the rest home (36 residents), the fifth shift is available to support across both areas. During the night there are two HCAs with support by a registered nurse.</p> <p>Additional staff are often rostered for higher acuity residents and/or days when the workload is higher (admissions and interRAI for example) and this was seen on the roster.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN, and clinical and facility manager who respond quickly to after-hour calls.</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>Radius Thornleigh utilises a paper-based medication management system. There are medication policies and procedures that follow recognised standards and guidelines for safe medicine management.</p> <p>All residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly blister pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy.</p> <p>Short-life medications (i.e., eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Ten medication charts reviewed identified that the GP</p>

		<p>had seen the resident three-monthly. A registered nurse was observed administering medications and followed correct procedures.</p> <p>There were no expired medications stored. Controlled drug documentation was fully completed, and this is an improvement from the previous audit.</p> <p>Documentation shortfalls have been identified and this is an area that continues to require improvement.</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 continues to employ a qualified chef and all food is cooked on-site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the chef works closely with the registered nurses on duty. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served. The service has an approved food control plan in place.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. The interRAI assessment tool is implemented and there are currently two RNs competent to use the tool. InterRAI assessments have been completed for all long-term residents and reviewed six monthly, or when there has been a change in the resident condition. The assessment process is an improvement from the previous audit.</p> <p>Pain assessments were documented as needed, as reviewed for one resident with documented pain control needed for back pain. Risk assessments had been completed through the computerised care plans for all residents, including the respite resident. All wounds had a completed assessment and associated wound management plan, and all residents had a completed GP assessment.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service</p>	FA	<p>All five resident files reviewed (four long-term and one respite) had an up-to-date and comprehensive care plan in place. The care plans reviewed described the support required to meet the resident's goals and needs. The respite (YPD) file documented in-depth family input. The interRAI assessment and other assessment tools undertaken inform the development of the resident's care plan. Residents and their family/whānau interviewed, reported that they are involved in the care planning and review process. Staff interviewed reported they found the long-term care plans easy to follow. Care planning interventions are an improvement from the previous audit.</p>

delivery.		
<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>Registered nurses and healthcare assistants follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the registered nurse will initiate a referral (e.g., to the district nurse, or wound specialist nurse). If external medical advice is required, this will be actioned by the GP.</p> <p>Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described.</p> <p>On the day of audit, there were six wounds and no residents with pressure injuries. All wounds had an assessment, management plan and evaluation documented in the electronic care planning system. All wounds have been reviewed in appropriate timeframes.</p> <p>There was evidence of pressure injury prevention interventions such as turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.</p> <p>As part of follow up of previous audit shortfalls, three incident forms for residents with falls (where the resident had hit their head) were reviewed. All had neuro observations completed as per policy and progress notes reflected the incident. Two residents on turning charts were reviewed and these were all documented. One rest home resident with behaviours that challenged had a monitoring chart completed. Monthly weighs were in place for all residents reviewed. Two residents had unintentional weight loss, both had weights consistently documented, both were given fortified drinks which were documented as taken. One of the files was reviewed specifically due to weight loss and this resident's weight was creeping back up as a result of interventions. The other resident was declining in health and was being reassessed for a higher level of care.</p> <p>Review of documentation identified an improvement from the previous audit.</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>	FA	<p>The service employs a full time diversional therapist and a part time activities coordinator. Between them they provided activities in the rest home and hospital over five days a week. Occasional activities are also provided over the weekend. Community linkages are documented and community involvement in the service was evidenced to be high. The activity programme includes the opportunity for residents to take an active part in assisting others; such as residents baking and delivering to people in need, 'candy bomb' (giving sweets away) and assisting with poppy day.</p> <p>Activity assessments and care plans are comprehensively documented. Three new resident files were reviewed for residents admitted within the last year. All had a completed social/activities assessment as part of the computerised assessment process. Activity plans are reviewed six monthly as part of the six-monthly care</p>

		<p>plan evaluation process and interRAI review.</p> <p>Individual activities care plans and goals are developed. A record of individual attendance at activities is documented. Residents in both areas were partaking in activities during the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and updated on the computer software programme. There was documented evidence that care plan evaluations were current in resident files sampled. Care plan evaluations are signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated.</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>A current building warrant of fitness is prominently displayed. Reactive and preventative maintenance occurs.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. The most recent fire evacuation drills were August 2017 and February 2018. This is an improvement since the previous audit. A contracted service provides checking of all facility equipment including fire equipment. Fire training and security situations are part of orientation of new staff and include competency assessments. Emergency equipment is available at the facility. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. Short-term back up power for emergency lighting is in place.</p> <p>A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times.</p> <p>There are call bells in the residents' rooms, and lounge/dining room areas. Residents were observed to have their call bells in close proximity.</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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections including suspected infections that are not treated with antibiotics. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided.</p> <p>Infection control data, trends and analysis is discussed at the monthly clinical and staff/management meetings. Data is sent to head office where the facility is benchmarked against other Radius facilities of similar sizes. Internal audits for infection control are included in the annual audit schedule.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. At the time of the audit there were no residents with restraint and no residents using an enabler. Staff training has been provided around restraint minimisation and the management of challenging behaviours. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.</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 1.3.12.1</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>	<p>PA</p> <p>Moderate</p>	<p>The registered nurses in the hospital and senior healthcare assistants in the rest home are responsible for the safe administration of medication. One medication round observed followed correct practice. However, a review of medication charts evidences that prescribing practices and signing for administration of medications are areas for improvement.</p>	<p>(i) Two of ten medication charts had short-term medications with no stop date documented. (ii) One of ten medication charts did not match the signing chart and this medication was signed for with a 'tick' rather than a signature.</p>	<p>(j) Ensure that short-term medications have a stop date documented and that (ii) medications administered are signed for with a signature and according to the medication chart.</p> <p>30 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.