# Riverleigh Care Limited - Riverleigh Residential Care

## 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:

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| **Legal entity:** | Riverleigh Care Limited |
| **Premises audited:** | Riverleigh Residential Care |
| **Services audited:** | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical |
| **Dates of audit:** | Start date: 30 January 2019 End date: 30 January 2019 |

**Proposed changes to current services (if any):** The service is converting an unused lounge area into a double room for rest home or hospital level residents. This will increase bed numbers from 64 to 66 beds.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 45

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

| Indicator | Description | Definition |
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| | 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

Riverleigh Residential Care provides rest home, hospital level care and residential disability services (physical) for up to 66 residents. On the day of audit there were 45 residents in total.

Since previous audit, the service is planning to convert an unused lounge into a double room. This audit verified the room as suitable for rest home or hospital level residents. Resident beds numbers will increase from 64 beds to 66 beds.

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 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 with significant health management experience and works full-time. She has been in the position for three and a half years. She is supported by a clinical coordinator who has been in the role for four months and an owner/director who visits the site on a weekly basis. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The service has addressed four of five shortfalls from the previous provisional audit around complaints documentation, medication documentation, admission agreement and infection control coordinator training. Improvements continue to be required in relation to specific training for younger persons and low attendance for compulsory training.

This surveillance audit identified a further improvement required in relation to residents self-medicating and reconfiguring the double-room.

## Consumer rights

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

There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## Organisational management

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

Riverleigh Residential Care has established a quality and risk programme. Progress with the quality and risk management programme is monitored through the monthly quality/staff meetings. Data is collected on complaints, accidents, incidents, infection control and restraint use. There is a current 2018-2019 business plan in place. Resident/relative meetings are held monthly. There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice.

The internal audit schedule for 2019 is being completed as per the schedule. The service has an annual training plan for in-service education. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

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

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. There is a medication management system in place that follows appropriate administration and storage practices. 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 activities coordinator. 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

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

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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

Riverleigh Residential Care has restraint minimisation and safe practice policies and procedures in place. On the day of the audit there was one resident with a restraint and five residents using enablers. Resident files reviewed evidenced enabler assessments and current care plans that identified risks associated with the use of the enabler. Staff receive training in restraint minimisation and enabler use.

## Infection prevention and control

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

The 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) |
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| **Standards** | 0 | 15 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 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) |
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| **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 |
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| Standard 1.1.13: Complaints Management<br>The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The service has a complaints policy that describes the management of complaints process. There are complaint forms available at the service entrance. Information about complaints is provided on admission. Interviews with residents and relatives confirms an understanding of the complaints process. A complaints register records all dates of initial response times and communication of the outcomes. There have been nine complaints made since the last audit. The complaints reviewed have been managed appropriately with acknowledgements, investigation and responses recorded. The previous finding relating to the complaints procedure has now been addressed. Residents and the family members interviewed advised that they are aware of the complaints procedure and how to access forms. Family members stated that the new management team work with them to ensure they are happy with services. |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an | FA | There is a policy to guide staff on the process around open disclosure. Residents and family are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement. The information pack is available in large print and advised that this can be read to residents. Six residents (two hospital younger persons and four rest home) and four relatives (three hospital and one rest home) interviewed confirmed that management and staff are approachable and available. Staff were observed communicating effectively with residents. Ten incident forms reviewed identified family were notified following a resident incident. Relatives interviewed confirm they are notified of any incidents/accidents. Families are invited to attend the |

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| environment conducive to effective communication. | | monthly resident/relative meeting. Riverleigh Residential Care has a number of younger people including residents on younger person with disabilities (YPD) contracts. |
| Standard 1.2.1: Governance<br><br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Riverleigh Residential Care provides rest home, hospital and residential disability (physical) level care for up to 66 residents. Since previous audit, the service has converted an unused lounge into a double room. This audit verified the room as suitable for rest home or hospital level residents (link 1.4.2.1). Resident beds numbers have increased from 64 beds to 66 beds. On the day of audit, there were 45 residents in total. Seventeen residents were requiring rest home level care, including two residents on respite care and one on long-term support chronic health condition (LTS-CHC) contract. There were 28 residents requiring hospital level care, including, 4 residents on respite care, 2 residents on a LTS-CHC contract and 6 younger persons with disabilities (YPD) residents. All of the beds are dual purpose use as either rest home or hospital level.<br><br>The service has a clearly defined scope, direction and goals documented in the 2018/2019 business plan and quality and risk plan. The facility is managed by an experienced manager who is a registered nurse (RN) and has been in this position for three and a half years. The facility manager is supported by a clinical coordinator, who has been in the role for four months and has over ten years' experience as an RN. The clinical coordinator is responsible for oversight of the clinical service in the facility. The facility manager is supported by the owner/director who visits on a weekly basis.<br><br>The facility manager has completed more than eight hours of training in the last year relating to the management of an aged care facility by attending regular professional development and industry conferences. |
| Standard 1.2.3: Quality And Risk Management Systems<br><br>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Riverleigh Residential Care has an established quality and risk programme. Progress with the quality and risk management programme is being monitored through the monthly quality/staff meetings. The quality/staff meeting minutes sighted evidence there is discussion around quality data including health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results and any corrective actions required. Meeting minutes have been maintained and staff are expected to read the minutes. Minutes for all meetings have included actions to achieve compliance where relevant. Data is collected on accident/incidents, infection control, complaints and restraint use. At the time of the audit, the service was reviewing the use of policies and procedures through an aged care consultant.<br><br>The internal audit schedule for 2019 is being completed as per schedule. Areas of non-compliance identified at audits have been actioned for improvement. There is an implemented health and safety and risk management system in place including policies to guide practice. A health and safety representative (maintenance person) was interviewed about the health and safety process. There is a current hazard register in place. Staff confirmed they are kept informed on health and safety matters at the quality/staff meetings. An annual residents/relative's satisfaction survey is due to be sent out at the end of 2019. Falls prevention strategies are in place that includes |

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| | | the identification of interventions on a case-by-case basis to minimise future falls. |
| Standard 1.2.4: Adverse Event Reporting<br><br>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | There is an incident reporting policy that includes definitions and outlines responsibilities. Ten accident/incident forms were reviewed for January 2019. All document timely RN review and follow up. Neurological observation forms were documented and completed for one unwitnessed fall with a potential head injury. There is documented evidence the family had been notified of any incidents. Discussions with the facility manager confirmed an awareness of the requirement to notify relevant authorities in relation to essential notifications including section 31 notifications. There have been no section 31 notifications lodged since the last audit. |
| Standard 1.2.7: Human Resource Management<br><br>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Moderate | There are human resources policies to support recruitment practices. Five staff files (one clinical coordinator, one RN and three caregivers) were reviewed. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Performance appraisals were current. A current practising certificate was sighted for the clinical coordinator. The service has an orientation programme in place to provide 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 are adequately orientated to the service.<br><br>There is an annual education planner in place for 2019 and the planner for 2018 has been completed. Staff training provided did not evidence training related to specific needs for younger people. A review of all training evidences that some subjects have a low attendance rate. A competency programme is in place with different requirements according to work type. Core competencies are completed annually, and a record of completion is maintained (as evidenced in the electronic database). Competencies include (but not limited to): fire safety; medication; manual handling; controlled drug checking; use of restraint; infection control; and wound care. Four out of nine permanent RNs and the clinical coordinator are interRAI trained. Registered nurses are also able to attend external training sessions provided by the local DHB. |

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| Standard 1.2.8: Service Provider Availability<br><br>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Riverleigh Residential Care has a weekly roster in place which provides sufficient staffing cover for the provision of care and service to residents. Staffing rosters were sighted and there is an adequate number of staff on duty to meet the resident's needs on different shifts. The facility manager and clinical coordinator are on-site during the day from Monday to Friday and share the on-call 24/7 duties. Roster shortages or sickness are covered by casual or off duty staff. The local general practice service also provides after-hours phone advice if required. Interviews with caregivers and residents identified that staffing is adequate to meet the needs of residents. Staff reported that management are supportive of staffing needs and assist when required.<br><br>The service is divided into two wings. In the Tui wing on the first floor, there are 27 residents in total (13 rest home and 14 hospital, including 3 YPD residents). There is one RN and three caregivers (two long and one short shift) in the morning shift, one RN and three caregivers (two long and one short shift) in the afternoon shift and one RN (shared between Tui and Kiwi wings) and one caregiver on the night shift.<br><br>In the Kiwi wing on the ground floor, there are 18 residents in total (4 rest home and 14 hospital including 3 YPD residents). There is one RN and three caregivers (two long and one short shift) in the morning shift, one RN and three caregivers (two long and one short shift) in the afternoon shift and one RN (shared between Tui and Kiwi wings) and one caregiver on the night shift. |
| Standard 1.3.1: Entry To Services<br><br>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | There are policies and procedures to guide entry to services, including a comprehensive admission policy. Information gathered on admission is retained in residents' records. Relatives interviewed stated they were well informed upon admission. The service has an information pack available for residents/families/EPOA at entry. The admission agreement reviewed aligns with the Aged Related Residential Care (ARRC) agreement which is an improvement on the previous audit finding. Time lines for repayment of overpaid monies and exclusions from the service are included in the admission agreement. |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with | PA Low | The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. A computerised medication system is in use. A paper-based medication system is used for respite residents. All residents have individual medication orders with photo identification and allergy status documented. The service uses a two-weekly medication roll system for tablets and other medicines are pharmacy packaged – including medications for respite residents. All medicines are stored securely when not in use. A reconciliation check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. |

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| current legislative requirements and safe practice guidelines. | | Short-life medications (eg, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the RNs who administer medications. Administration records sampled were appropriately signed. Ten medication charts reviewed identified that the GP had seen the resident three-monthly and the medication chart was signed each time a medicine was administered by staff. Two RNs were observed administering medications and both followed correct procedures. The effectiveness of all PRN medication is recorded on the electronic system and in the progress notes for all regular medication. The previous finding relating to medication documentation have been addressed. One resident self-administers medicines. There was no documented evidence that the resident has been deemed competent. Standing orders are not used. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management<br><br>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | There is a fully equipped commercial kitchen on-site. The qualified chef leads in the preparation and cooking of food on-site. There is a weekend cook and morning and afternoon kitchen hands. All kitchen staff have completed food safety training. The menu in use has been approved by a dietitian but is due to be reviewed again. The food safety plan which has been written is currently being reviewed. A food services manual is available to ensure that all stages of food delivery to residents comply with standards, legislation and guidelines. All fridges and freezer temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily at the end of cooking and upon serving.<br><br>All food is served directly from the kitchen to residents in the dining room or to their rooms on trays as required. All food in the freezer and fridge was labelled and dated. All residents have a nutritional profile developed on admission, which identifies their dietary requirements, likes and dislikes. This profile is reviewed six-monthly as part of their care plan review. Changes to residents' dietary needs are communicated to the kitchen staff. Special diets can be catered for and there is a choice of the main meal each day. Residents (including one YPD) and relatives interviewed reported satisfaction with food choices and meals, which were well presented. |
| Standard 1.3.6: Service Delivery/Interventions<br><br>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Five resident files were reviewed. All include care plan interventions to support current assessed needs. When a resident's condition alters, the registered nurse initiates a review and if required a GP consultation. The family members confirmed on interview they are notified of any changes to their relative's health including (but not limited to) accident and incidents, infections, health professional visits and changes in medications.<br><br>Short term care plans were utilised to highlight changes to care or changes were made to the long-term care plans as appropriate.<br><br>Continence products are available and resident files include a urinary continence assessment, bowel management and continence products identified. Registered nurses were able to describe access for wound and continence specialist input as required. |

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| Standard 1.3.7: Planned Activities<br><br>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There is an activities coordinator (with Health & Wellbeing Support qualifications) employed full-time Monday to Friday who is assisted by another for two hours each afternoon. The coordinator is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities five days a week. Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits. Individual activities are provided in residents' rooms or wherever applicable. On the day of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly with input from residents, and a copy of the programme is available on noticeboards throughout the facility and also on the recently installed electronic care monitoring and communication system, which can communicate to the display board in each resident's bedroom information on upcoming activities.<br><br>The activities coordinator does an assessment of the resident on admission. The resident/family/EPOA, is involved, as appropriate, and an activities plan is incorporated in the resident's long-term care plan. Evaluation is undertaken when the plan is reviewed. There was no specific documentation of this evaluation. The younger person disabled resident file reviewed indicated that the resident was independent with what she did, whether it be joining in with 'in-house' activities or accessing the community – on interview the resident confirmed this. A record is kept of individual resident's activities is maintained. Participation in all activities is voluntary. Residents interviewed described van outings (now increasing to two a month), musical entertainment (twice-monthly) and attendance at a variety of community events. |
| Standard 1.3.8: Evaluation<br><br>Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents under the ARRC contract are reassessed using the interRAI process six-monthly or if there has been a significant change in their health status. Other long-term residents are reviewed using the computer-based assessment process. Long-term care plans are then evaluated and rewritten. Care plan reviews are signed as completed by the RN. The files sampled documented that the GP had reviewed residents at least 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 RNs interviewed explained the communication process with the GP. |
| Standard 1.4.2: Facility Specifications<br><br>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for | PA Low | A current building warrant of fitness expires on 24 September 2019. This audit has assessed the service to be able to utilise an unused lounge area as a large double bedroom for rest home or hospital level residents. There are sufficient shower/toileting facilities adjacent to cater for two additional residents. An electronic call bell tracking system is installed in each of the resident's rooms. On audit, the room was awaiting the installation of a hand basin, privacy screening and separate call systems. |

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| their purpose. | | |
| Standard 3.4: Education<br><br>The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator has completed external training to support her role. The previous finding relating to external education of the infection control coordinator has now been addressed. |
| Standard 3.5: Surveillance<br><br>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator (clinical coordinator) collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in place that are appropriate to the size and complexity of the facility. There have been no outbreaks since 2017. |
| Standard 2.1.1: Restraint minimisation<br><br>Services demonstrate that the use of restraint is actively minimised. | FA | Riverleigh Residential Care has restraint minimisation and safe practice policies and procedures in place. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. On the day of the audit there was one resident with a restraint (bedrails) and five residents using enablers (all bed rails). Three resident files reviewed evidenced enabler assessments and current care plans that identified risks associated with the use of the enabler. The use of the enabler was voluntary. Restraint and enabler education is included in the two-yearly training programme and last occurred in June 2018. |

# 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) |
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| Criterion 1.2.7.5<br>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Moderate | There is a two-yearly education plan in place that includes all required education as part of these standards. Individual training is recorded in an electronic database. Not all specific compulsory education had been completed in the two-yearly education plan and attendance has been low. | (i) There has not been any specific staff training provided to meet the needs for younger people.<br>(ii) Compulsory in-service training attendance for continence, pressure injury prevention and falls prevention has been low. | (i) Provide training for staff related to caring for younger people.<br>(ii) Ensure staff attend compulsory training for continence, pressure injury prevention and falls prevention.<br>60 days |

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| Criterion 1.3.12.5<br>The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | There is a policy and guidance for when residents self-medicate, including assessment and documentation of the resident's competency and safe storage in their room. One resident has no documentation completed to reflect the resident was competent. | One resident was self-medicating. Medications were under lock in the bedroom, but there was no evidence the resident had been deemed competent to self-medicate | Ensure resident's self-medicating are deemed competent at least three monthly<br><br>60 days |
| Criterion 1.4.2.1<br>All buildings, plant, and equipment comply with legislation. | PA Low | There is a current building warrant of fitness. Reactive and preventative maintenance is completed. This audit has assessed the service to be able to utilise an unused lounge area as a large double bedroom for rest home or hospital level residents. The room was awaiting the installation of a hand basin, privacy screening and separate call systems | The double bedroom verified as part of this audit was identified as suitable for a couple. However, the room was awaiting the installation of a hand basin, privacy screening and separate call systems | Ensure a hand basin, privacy screening and separate call systems is in place.<br><br>Prior to occupancy days |

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

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

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

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

| No data to display |
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End of the report.