Freeling Holt Trust - Freeling Holt House

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 Q-Audit 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:	Freeling Holt Trust
Premises audited:	Freeling Holt House
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical
Dates of audit:	Start date: 12 April 2019 End date: 12 April 2019

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: 32

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
	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

Freeling Holt House provides rest home and hospital level of care for up to 35 younger and older people. There were 32 residents at the time of audit (one rest home, 19 hospital and 12 younger people). Residents and families report satisfaction and positivity about the care, services and activities/lifestyle options provided.

This certification audit was conducted against selected Health and Disability Services Standards and the services contract with the district health board. The audit process included review of records and interviews with residents, families, management, clinical and non-clinical staff and a general practitioner.

Two shortfalls were identified related to maintaining up to date medications and to activities planning documentation. No other issues were identified at this audit.

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.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. There is access to interpreting and translating services as required. There were advance care plans and advance directives that record the residents wishes, with these respected by the staff. There are processes to ensure that all staff and doctors are aware of their existence.

There is a documented complaints process in place that complies with the Code. A register is maintained with evidence that appropriate action is promptly taken to address any issues. There were no outstanding complaints.

There is a documented open disclosure policy in place. Open communication between staff, residents and families is promoted, and confirmed to be effective.

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.

A business plan and quality and risk management plan are documented and includes the mission and goals of the service. There is a process in place for the regular reporting to management and the board against these goals.

The organisation is managed by an experienced and suitably qualified facility manager with a registered nurse clinical manager who deputises for the manager as required.

Quality management data is collected and discussed at staff meetings and staff were able to describe this. There is an implemented internal audit programme. Corrective action plans are in place where necessary. Adverse events are documented and there is evidence of improvements implemented based on the findings. Adverse event reporting includes records of open disclosure where required.

Policies on human resources management are in accord with current accepted practice. Practising certificates are current for all registered nurses and associated health professionals. Staff records have the required information, including staff education records. An orientation programme is in place and completed by all new staff. Staff report access to in-service and external training.

There is a documented rationale for determining staffing levels and skill mix in order to provide safe service delivery. There is always a manager and a suitable deputy on site or on call. A registered nurse and at least two caregivers are on site 24 hours a day. Care staff reported there are adequate staff available.

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.

Assessments and care plans are completed and evaluated by the nursing team. Activities plans are completed by the activities coordinator in consultation with registered nurses (RNs), staff and family/whanau. Planned activities are appropriate to the residents' assessed needs and abilities. Family/whanau expressed satisfaction with the activities programme in place.

Medicine management policy is in place and meets legislation and regulatory requirements. Medicines are reviewed by the general practitioner (GP) in a timely manner. The service uses an electronic system in e-prescribing, dispensing and administration of medicines. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with recognised nutritional guidelines and residents with special dietary needs are catered for.

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.

The building complies with relevant legislation and a current building warrant of fitness is displayed. The preventative maintenance programme includes equipment servicing, calibration and electrical checks. The environment is appropriate to the needs of both younger and older residents. The facility was originally designed in a cottage layout to suit younger people with disabilities. The five cottages/wings are now connected through enclosed walkways.

Essential emergency and security systems are in place with biannual fire drills completed. A call bell system allows residents to access help when needed. Electronic records and residents interviewed confirmed that bells are responded to in a timely manner.

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.

There are clear and detailed documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint and 22 residents were using enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and confirmed that they receive ongoing education in the 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.

There is a documented infection surveillance program. The infection control coordinator collates, analyses and evaluates the monthly infection data. The type of surveillance is appropriate to the size and complexity of the service. Infection rates are discussed in the staff meetings and other clinical meetings. Action plans are developed to reduce the incidence infections. Possible root causes are also investigated.

Infection control experts are available and consulted by the infection control coordinator when required.

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	16	0	2	0	0	0
Criteria	0	42	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

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 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	There are guidelines in the informed consent policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. An advance directive from and advance care plan are used to enable residents to choose and make decisions related to end of life care. The files sampled have signed advance directive forms and advance care plans that identify resident wishes and meet legislative requirements. Training is provided to staff and there is a process in place to keep staff informed of the resident's advanced directive wishes.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Information about the complaints process is provided to residents and families as part of the admission process with at least annual updates for residents/families with visits from the advocate. There are complaints forms available throughout the service. The residents and families reported that they feel free to make a complaint if they need to. The residents and families report that issues are addressed almost immediately if they have any concerns. The complaints register contains the complaints, dates and actions taken. All complaints are satisfactorily closed. One complaint received via the DHB in July 2018 has been addressed and closed. The complaints sampled

		reflected timeframes within right 10 of the Code.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. The residents and families report that communication is open and honest. Open disclosure is documented in residents notes and is noted on incident forms The cultural policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. This service can be contacted through the district health board (DHB). Files sampled of residents who do not speak English or are not able to communicate verbally, show that effective methods of communication are implemented.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The services are planned to meet the needs of the younger and older residents at the different levels of care, abilities and specific care/rehabilitation needs. The service was originally designed for younger people with disabilities, then changed to include older people at rest home then hospital level of care. All rooms are classified as dual purpose (able to accommodate either rest home or hospital level of care). Within the hospital level of care services, the organisation provides long term, short term and respite care for people with chronic health conditions (contract with the DHB) and rehabilitation services (through contracts with ACC) as well as palliative/end of life care services. At the time of audit, the 19-hospital level of care residents included residents referred through ACC. Of the 12 residents living with lifelong disabilities, six of these residents are now over the age of 65. The organisations mission, values, philosophy and beliefs are clearly documented in the business plan. The business plan is reviewed on an annual basis. The organisation has a person-centred approach to service delivery. The service is operated by a charitable trust and governed by a board of trustees. The day to day management of the services is conducted by a full-time facility manager. The facility manager provides a monthly report to the board on progress towards meeting organisational goals. The facility manager has been in the position for 8 months (since August 2018) and at the service for eighteen years. The facility manager has appropriate management qualifications and has attended more than 20 hours education in the past 12 months related to residential aged care management. The organisation is a member of an aged care association and the facility manager receives weekly updates on issues related to aged care industry. The facility manager maintains ongoing professional knowledge and downloads updates from the Ministry of Health related to the aged care industry. The facility manager was the admin manager prior to taking on the facility management role. The charge nurse has been with Freeling Holt House since 2013 is now the

		clinical manager (appointed in September 2018). The role of both positions is clearly defined in the relevant job descriptions.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	The quality and risk plan were last reviewed and updated in November 2018. Each of the quality goals incorporated processes of effectiveness, safety, responsiveness and accessibility fundamental to health and disability service provision. There are goals and objectives for all aspects of service delivery. The staff meetings provide a forum for discussing quality and risk issues, as confirmed in the review of meeting minutes and interviews with staff. The staff interviewed demonstrated knowledge of the quality and risk management systems. Staff are involved in the quality and risk management systems, and internal audits can be done by different members of the team. There is a documented process for the development of policies and procedures. The policies and procedures have been developed by an aged care consultant, and personalised to the organisation. The policies are reviewed on a two-year cycle, or sooner if there are any best practice or legislative changes. The facility manager receives updates from the aged care consultant as policies are updated. Staff only have access to the most recent version of policies and procedures. The obsolete documents are archived. There is a system in place to enable the retrieval of documents as needed. Archiving and destruction of records is conducted in line with legislation. The internal auditing system (including safety inspection and satisfaction surveys) is used to monitor the quality and risk management systems. The internal audit schedule covers all aspects of service delivery (including pressure injury management). The internal audits sampled record the aim, method, frequency, audit outcomes, frequency, comments and recommendations. If shortfalls are identified, corrective action/quality improvement plans are commenced. The corrective action plans sighted record the area for improvement, the improvement plan, who is responsible, time frames for implementation and measurable improvement indicators to review if actions implemented have been effective. Feedback from the improvements is shared with staff at the staff meetings. The two monthly management meeting includes the analysis the quality data. The results are communicated with staff at handover and at the staff meetings. The resident meetings provide opportunities for the residents (including the younger residents) to provide feedback on service delivery and quality improvements. The younger residents report satisfaction with choices, decision making, access to technology, aids, equipment and services. The organisation has conducted a number of quality improvements since the last audit. These identify the area for improvement, evaluate their current performance, set goals to improve performance, the actions taken to implement the improvement, evaluation of the effectives of the actions and identify any further areas of improvement that can be implemented to make further improvements. The business plan includes risk analysis and strengths, weakness, opportunities and threats analysis. This

		records organisational risks, actions implemented and monitoring requirements to reduce/minimise the occurrence or impact of the risk. The service also has a hazard register that identifies the hazards in the facility and delivery of services. This includes risk minimisation strategies to address the risks associated with service provision. The internal auditing system, hazards checklists and inspections are implemented to monitor ongoing compliance.
Standard 1.2.4: Adverse Event Reporting 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	Adverse events are documented on an incident/accident form and these are followed up by the facility manager and the clinical coordinator. Forms are well annotated with follow-up actions. All serious incidents/accidents are reported to the registered nurse on duty. There is a monthly collection and analysis report of the incidents that have occurred. Remedial actions implemented to make improvements are reviewed at the management meeting (meeting combines management, infection control, health and safety, quality). Staff confirmed that they are made aware of their responsibilities in this regard during their orientation and in policy and procedures. The facility manager interviewed is aware of the essential notification requirements and these are documented in policy. The change of facility manager was notified to the Ministry on 29 September 2018. The facility manager advised that there have been no notifications of significant events made to the Ministry of Health or other agencies since the last audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	All staff and contractors who require a practicing certificate have these verified annually. Current practicing certificates were sighted for all staff who require them. There are policies and procedures on human resources management. The skills and knowledge required for each position within the service is documented in job descriptions which were evident on each personal record sighted. An orientation process covers all essential components of the services provided. There is also specific orientation training and competencies for the different roles. Staff members interviewed found the information provided to be informative and supportive. Staff annual performance appraisals were sighted in the staff files reviewed. There is an education plan for 2019 with several sessions confirmed with speakers. The service has access to a nurse educator and mentor for the RNs. The 2018 programme was sampled and evidenced that education is provided, in house, online and by staff visiting external facilities. All staff participate in continuing education relevant to physical disability and young people with physical disabilities. The individual records of education are maintained for each staff member and were reviewed. All relevant staff have medication competencies. Twenty-three staff have completed first aid. All six registered nurses are trained and assessed as competent in the interRAI assessment programme. Staff interviewed reported that they had good access to education and found

		the programme relevant to their work.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented policy for allocation of staff to meet the needs of the residents at different levels of care. The policy meets contractual requirements for the care staff ratios. The facility manager also uses an acuity tool to ensure the staff mix continually meets the changing needs of the residents. If there is an increase in the level of need (e.g. palliative or acute condition) the staffing is increased to meet these. There are always at least one registered nurse and two care givers on site 24 hours a day. Two care givers are on duty during mealtimes. Senior staff leave is scheduled to ensure that two staff capable of managing the service are available at all times. Care staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them. Actions required following a complaint to the DHB in July 2018 have been implemented and maintained. In addition to the care staff, there are sufficient numbers of physiotherapist/physiotherapist aids, activities/lifestyle coordinators, cooking, cleaning, laundry, administration and maintenance staff to meet the needs of the residents and ongoing running of the service. Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate care. Observations during the audit confirmed adequate staff cover is provided.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	PA Low	Staff responsible for medicine administration are assessed as competent and competencies are current. Three monthly medicines reviews are completed by the GP. Allergies or sensitivities are indicated, and residents' photos are current. The RN was observed administering medicines correctly using safe practice which complied with legislation and guidelines. There were controlled drugs on site and weekly and six-monthly stock takes were completed. Medicines were safely and securely stored in locked cupboards. There were no resident self-administering medicines on the day of the audit. A self- administration policy is in place if required. Medicines audits are conducted, and corrective actions are acted upon. The checking and returning expired as required (PRN) medicines could be improved.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and	FA	The food service is outsourced and meals are prepared on site and served in the allocated dining room. The menu was reviewed by a registered dietitian. Diets are modified as required and the cook confirmed awareness of dietary needs of the residents. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. The family/whanau interviewed acknowledged

nutritional needs are met where this service is a component of service delivery.		satisfaction with the food service. The kitchen was audited and registered under the food control plan. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were clean, tidy and stocked. Labels and dates are on all decanted food containers. Records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documented interventions in short term care plans and long-term care plans were sufficient to address the residents' assessed needs and desired goals/outcomes. The files sampled, specified prevention-based strategies for minimising episodes of challenging behaviours in the event of any challenging behaviour episodes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed each shift. Wound assessment, monitoring and wound management plans are in place for residents. The nursing team has access to a wound care specialist for advice. Adequate clinical supplies are available, and interviewed staff confirmed they have access to enough supplies. Family/whanau members interviewed reported satisfaction with the care and support their families/whanau are receiving. Evidence was sighted that the previous area requiring improvement relating to documentation of short-term care plans has been addressed and maintained.
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.	PA Low	The planned activities are meaningful to the residents' needs and abilities. The activities are based on assessment and reflect the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests and enjoyments. Residents' profile is completed in consultation with the family during the admission process. There is an area for improvement related to using the interRAI assessment outcomes. Residents were observed participating in a variety of activities on the audit day. There are planned activities and community connections that are suitable for the residents. There are regular outings for all residents (as appropriate). Family/whanau interviewed reported overall satisfaction with the level and variety of activities provided.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and	FA	The nursing team is responsible for evaluating long term care plans at least every six months or earlier when a change in health status is noted. The activities coordinator evaluates activity plans in consultation with the nursing team (Refer 1.3.7.1). Residents are regularly reviewed by the GP, at least every three months or more frequently when required. Evaluations include the residents' degree of achievement towards desired goals/outcomes. Residents' response to treatment is documented in the short-term care plans and resolutions are documented. Family/whanau and staff are consulted during the review process.

timely manner.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a preventative maintenance schedule, which records the frequency of the inspections and maintenance regime. Medical equipment records a current calibration certification. The electrical equipment has current test and tagging records. There are weekly and monthly safety inspections conducted by the maintenance worker. Hot water checks are conducted monthly, with all readings below the maximum temperature. The maintenance worker and the facility manager meet weekly to review the maintenance and upkeep of the facility. Monthly inspection reports are tabled at the manager's meetings. The physical environment is designed to reduce risk and optimize freedom of mobility. The corridors are wide enough to enable mobility aids and fitted with handrails to encourage independent mobility. The facility is designed in five wings/cottages that are linked with uncovered and enclosed walkways. Each resident room has direct external access to courtyards and garden areas. There are concrete ramps to enable disability access. There is a secured spa pool, that has a hoist to enable disability access. There is a lift and external footpaths to gain access to the lower/back garden and recreation area (includes the spa pool).
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved evacuation scheme, with six monthly evacuation drills, last conducted in 16 October 2018. There have been no alterations to the services or the buildings since the last audit. The staff receive training on fire safety and emergency procedures as part of their orientation and ongoing education. The staff demonstrated knowledge of how to respond in emergency situations. The service is fitted with fire suppression equipment. Fire equipment testing is conducted, with the annual check last conducted in Nov. 2018. There are monthly inspections by a contracted company for compliance with fire, emergency and building warrant of fitness ongoing compliance.
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	Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. The surveillance activities are appropriate to the size and setting of the service. Monthly infection data is collected for all infections based on signs and symptoms of infections. The infection data results are evaluated and discussed in the monthly staff meetings. GPs are informed of infections in their residents. Specific recommendations to reduce and manage infections are evidenced in the monthly staff meeting minutes. .

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Freeling Holt House actively works to minimise the use of restraint. An updated restraint register was sighted, and staff interviewed understand the difference between restraint and enablers. Risk minimisation is documented in the care plans of the residents and restraint is evaluated regularly. Approved equipment which can be used as a restraint includes, bedrails and lap belt. There were no residents under restraint and 22 residents were using enablers. The family/whanau are informed about the restraint/enabler use process and risks involved. Reports about restraint and enabler use statistics are discussed during management and health and safety meetings. All staff complete a restraint minimisation competency during orientation and ongoing education is provided on challenging behaviour and de-escalation techniques.

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)
Criterion 1.3.12.1 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.	PA Low	There are policies and procedures in place that clearly document the service provider’s responsibilities in each stage of medicine management. The service uses an electronic medicines system and outcomes of PRN medicines are recorded. An improvement is required to ensure that expired PRN medicines are returned to the pharmacy in a timely manner.	The medicine management system, storage and disposal does not meet current legislative requirements	Ensure that expired PRN medicines are returned to the pharmacy in a timely manner. 180 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the	PA Low	Residents’ files sampled reflected their preferred activities and were evaluated every six months or as when necessary but the activity care plans were not evaluated using interRAI assessment outcomes. The activities coordinator develops an activity planner for all residents	Activity care plans were not evaluated using interRAI assessment	Provide evidence that activity care plans are evaluated

consumer.		and these are posted on the notice boards and distributed to resident rooms.	outcomes.	incorporating interRAI assessment outcomes. 180 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

End of the report.