

Ambridge Rose Manor Limited - Ambridge Rose Manor

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:	Ambridge Rose Manor Limited
Premises audited:	Ambridge Rose Manor
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 10 June 2019 End date: 10 June 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:	102

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

This unannounced surveillance audit was conducted against the Health and Disability Service Standards and the service's contract with the district health board (DHB). Ambridge Rose Manor provides rest home and hospital level care for up to 104 residents and there were 102 residents at the time of the audit.

There have been changes to the organisational structure since the last audit. A clinical manager and clinical lead were appointed in the management team.

The audit process included the review of policies, procedures, residents and staff files, observations and interviews with residents, family, management, staff and the general practitioner.

There were two identified areas requiring improvement. The improvements are related to care plans not being developed in conjunction with interRAI assessments and as required medications (PRN) medicines outcomes not documented.

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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There is a policy on open disclosure of any events that may adversely affect the resident. Documenting of open disclosure following incidents/accidents was evident. Residents and families interviewed reported they are informed of any events or concerns. Advanced directives are discussed with residents during the admission process and information is included in the residents' handbook. Interpreters are available if required.

Complaints are addressed promptly in accord with Right 10 of the Health and Disability Consumers Code of Rights (the Code). Managers are aware of external reporting requirements.

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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The directors/owners govern the organisation. Day to day operation of the facility is the responsibility of the chief executive officer (CEO), and the chief operations officer (COO). A new clinical manager and a clinical lead registered nurse have been appointed since the last audit. Organisational performance is monitored. The mission and strategic goals are documented and reviewed.

Quality and risk management systems support service delivery. Achievement towards quality goals is measured. Adverse events and complaints are managed in accord with documented policy and the requirements of the Code. Internal audits are conducted, and results used to inform improvements to services. Collated quality and risk data are providing full analysis on trends and

themes. The required policies and procedures are documented, reviewed and controlled. Quality activities are monitored and communicated throughout the organisation.

Human resource processes support good employment practice. All staff receive an orientation. Ongoing training is provided, and staff competencies are assessed and monitored. There are always adequate numbers of skilled staff on duty.

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 medium or high risk and/or unattained and of low risk.
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The nursing team is responsible for the development of care plans with input from residents, staff and family member representatives. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems as they arise. Files reviewed demonstrated that the care provided and needs of the residents are reviewed and evaluated in a regular and timely manner.

The planned activity programme provides residents with a variety of individual and group activities and maintains links with the community. Medicines are safely managed and administered by staff with current medication competencies. All medications are reviewed by the general practitioner (GP) every three months or when required.

The food service meets the nutritional needs of the residents and special diets 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.
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The facility was purpose built and has a current building warrant of fitness. Ongoing maintenance and compliance monitoring ensure that the physical environment meets the needs of the residents and health and safety requirements. Electrical and medical equipment, furniture and fittings are maintained in safe working order. There is an approved evacuation plan and fire drills are conducted biannually. Emergency management plans and equipment are in place.

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 organisation has policies and procedures that support the minimisation of restraint. 19 restraints and three enablers were in use at the time of the audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. The use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler process.

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.

The infection control surveillance program is appropriate for the size of the facility and the complexity of services provided. Infection data is collated monthly, analysed and reported during staff meetings. Surveillance for infection is carried out as specified in the infection control programme.

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	1	1	0	0
Criteria	0	43	0	1	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
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	Policies and procedures on consent support the residents right to make informed decisions. In interviews conducted the staff demonstrated understanding of the principles and practice of informed consent. Records reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented. Residents interviewed confirmed that they were provided with day to day choices and consent was obtained.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected,	FA	Information about the complaints process is provided to residents/family on admission. The process and forms are readily available. The resident's right to complain is discussed with the resident and family. Interviews with residents and family confirmed awareness of their right to make complaints if they wish. The complaints register, and associated records indicate effective and timely handling of complaints in accord with Right 10 of The Code. Verbal concerns are discussed with management and at residents' meetings. Written complaints are added to the complaints register. The register includes the date, nature of complaint, action taken

<p>and upheld.</p>		<p>and resolution.</p> <p>Information about the complaints process is provided to residents/family on admission. The process and forms are readily available. The resident's right to complain is discussed with the resident and family on admission. Interviews with residents and family confirmed awareness of their right to make complaints if they wish.</p> <p>The complaints register, and associated records indicate effective and timely handling of complaints in accord with Right 10 of The Code. Verbal concerns are discussed with management and at residents' meetings. Written complaints are added to the complaints register. The register includes the date, nature of complaint, action taken and resolution.</p> <p>There have been two formal complaints received via the Health and Disability Commissioner and one via the District Health Board (DHB) since the last certification audit. Related records were sampled. All have been fully investigated and requirements for remediation, including a letter of apology to one complainant, have been implemented.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Staff education is provided related to appropriate communication methods. The service has required access to interpreting services for the residents. Policies and procedures are in place if the interpreter services are needed to be accessed. Documenting of open disclosure following incidents/accidents was evident. Families reported they are informed of any events or concerns.</p>
<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>	<p>FA</p>	<p>The organisation is governed by two directors/owners, one of whom is the chief operating officer (CEO). There have been two changes in senior personnel since the last audit. A clinical manager (senior experienced registered nurse) and a clinical lead (senior experienced registered nurse) have been appointed. Position descriptions and employment contracts meet clinical and contractual requirements. Both staffs are suitably qualified and experienced for the role. The strategic direction of the organisation has recently been reviewed. Goals and company objectives are defined in measurable terms.</p> <p>The facility holds three service agreements with the DHB for long term care and support, rest home care and hospital care.</p> <p>Organisational performance is monitored in an ongoing manner. The organisation chart defines reporting lines throughout the organisation. The quality manager reports to the chief operating officer (COO), and the quality manager and the COO reports directly to the CEO and directors. Operational management reports sampled</p>

		<p>confirmed organisation performance and monitoring of achievement towards the strategic goals does occur.</p> <p>Day to day management is the responsibility of the CEO and the COO. The COO is supported by the management team which consists of the quality manager and the clinical manager. The management team meets monthly. All members of the management team are suitably qualified and maintain professional qualifications in management, finance and clinical skills.</p> <p>The organisation provides 104 beds. All beds are approved as dual purpose and can accommodate residents who have been assessed as requiring rest home or hospital level care. The organisation also has a contract to provide respite services and long-term support for chronic health conditions through the DHB. At the time of the audit there were 12 rest home residents (none of whom were accessing the respite service) and 88 hospital residents, three of whom were under the long-term chronic contract. There were two residents under the age of 65 years old. All care is provided by employed staff. There have been only two bureau staff used in the last 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>	<p>FA</p>	<p>The quality and risk management framework are documented and implemented. This includes a description of quality goals and quality related activities. Staff receive an induction to quality activities during the orientation process.</p> <p>Organisational policies and procedures are purchased from an external contractor. Policies reflect standards, contracts, good practice, legislation requirements and are readily available to staff. All policies are subject to reviews and all policies sampled were controlled documents. Obsolete documents are archived, and staff are alerted to changes as they occur. Changes have been made to the assessment process for referral to speech language therapy and other allied health specialists in accord with the requirements issued following the investigation of a complaint made to the DHB.</p> <p>A range of quality related activities are conducted. Service delivery is monitored through complaints, surveys, health and safety, review of adverse events, surveillance of infections and implementation of an internal audit programme. The electronic data base provides a wide variety of reports and enables close monitoring and analysis of specified/chosen data.</p> <p>There is a documented and fully implemented internal audit programme that covers the scope of the quality system. An audit of the informed consent system has been conducted as required by the HDC following investigation of the complaint relating to restraint made to the Health and Disability Commissioner. There is evidence that any area of non-conformance is remedied and followed up. The results of internal audits are discussed at management and staff meetings. Internal audits are viewed by the COO. In addition, several quality initiatives are developed, implemented and evaluated.</p> <p>A risk management programme is in place. A risk matrix is documented. This includes health and safety processes and hazard management. There is evidence that business, environmental, clinical and financial risks</p>

		are monitored and discussed at operational management team meetings.
<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>Management and clinical leaders interviewed were aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. Review of incident records indicated that two events had been appropriately notified to the Ministry since the last audit.</p> <p>The service is committed to providing an environment in which all staff are able and encouraged to recognise and report errors or mistakes. Staff receive education at orientation on the incident and accident reporting process. Staff interviewed understood the adverse event reporting process and their obligation to documenting all untoward events.</p> <p>All adverse events are documented using the electronic data base. A range of incident reports were sampled. Each incident report had a corresponding note in the progress notes to inform staff of the incident. There is evidence of follow up with the GP and family members.</p> <p>The data base provides alerts which ensure all incidents are followed up and closed out in a timely manner. A full analysis of incidents is reported at management meetings. This includes discussions regarding any required improvements to the system.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Professional and trades qualifications are validated annually, including those required by external providers. All staff have an orientation which includes the essential components of service delivery. This includes training on emergency management. Staff who administer medications have the required competency assessments and enough staff have a current first aid certificate to ensure that every shift is covered. There are two registered nurses who can complete interRAI assessments. A further two RNs are in training.</p> <p>An in-service training plan is developed every two years. In-service education is held monthly, as per the training plan. Education and training hours exceeded eight hours a year for each staff member and include the required topics. Individual training records are maintained. Attendance at staff training is monitored by the quality manager. In interview, staff confirmed they have access to enough and relevant training opportunities.</p> <p>Staff performance is monitored, and annual performance appraisals were sighted in records sampled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive</p>	FA	<p>Rosters and duty lists are documented. Staffing levels are enough in number and take into consideration the layout of the building. There are two floors with two wings each. There are two registered nurses on duty during the day and one at night. Additional registered nurses are available on call if required. The clinical manager is on</p>

<p>timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>site Monday to Friday and a clinical lead registered nurse is rostered Tuesday to Saturday. There is a total of 65 health care assistants. Health care assistants are rostered over the 24-hour period, with three on during the day and one at night in each wing plus a runner on each floor at night. A clinical lead senior care assistant is rostered on for each floor. Rosters sampled confirmed that full cover is provided; this includes during a time of absence. Records of duty changes are maintained. Bureau staff are available, but very rarely required.</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>The medicine management policy is current and identifies all aspects of medicine management in line with current legislation and protocols. There is a safe electronic medication system in place. An enrolled nurse (EN) and healthcare assistant (HCA) were observed administering medication correctly. All staff who administer medicines were assessed as competent and evidence was sighted. There were no residents who self-administer medications at the time of the audit. Appropriate processes are in place to ensure this is managed in a safe manner if required. Outcomes of as required (PRN) medicines were not being documented.</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>	<p>FA</p>	<p>The food service is provided on site by qualified cooks and kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by the registered dietitian within the last two years. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.</p> <p>A nutritional profile is developed on admission and reviewed every six months or when there is any significant change. 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. Snacks and drinks are available for residents when required. Residents and family/whanau interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was registered under the food control plan. Kitchen staff completed training in food safety/hygiene. The kitchen and pantry were sighted and observed to be 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.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p>	<p>FA</p>	<p>The documented interventions in acute care plans and long-term care plans are enough to address the residents' assessed needs and desired goals/outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers when required. Referral</p>

<p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>documents to other services and organisations involved in residents' support were sighted in the files reviewed. Interviewed families and residents reported satisfaction with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate medical/clinical resources were sighted and were appropriate to the size of the facility.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>Activities are planned by the diversional therapist in consultation with two activities assistants. A monthly planner is distributed to all residents and posted on the notice boards that are accessible to residents. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Residents and their family/whanau are consulted in the activity's assessment and planning process. There is a wide range of activities offered including bingo, quiz, music sessions, walking groups, scrabble, happy hour and housie. External entertainers are invited, including church and music groups. Van outings are conducted once a week to areas of interest. Activities range from group, one on one and caters to those under 65 years of age. Attendance checklists and documentation is completed. The residents' activities needs are evaluated by the diversional therapist, in consultation with the nursing team six-monthly (refer 1.3.3.3).</p> <p>Monthly residents' meetings are conducted, outcomes are implemented and communicated to family/whanau and residents. Interviewed residents and family members reported satisfaction with the activities programme. Residents were observed participating in a variety of activities on the days of the audit.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the electronic progress notes and if any change is noted, it is reported to the nursing team. Residents' care plans, interRAI assessments and activities plans are evaluated at least every six months and updated when there are any changes. Family/whanau and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Acute care plans are developed when needed and signed and closed out when conditions resolve.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit</p>	<p>FA</p>	<p>The current building warrant of fitness was sighted. On-going checks on the environment are conducted to ensure it remains safe and compliant. This includes monthly inspections of security, fire safety systems, call bells and emergency lighting. A maintenance person is employed and there is evidence that any maintenance issues are addressed in a timely manner. A lift provides access between floors and has a current certificate. There are handrails in all corridors. Ramps have non-slip floor covering and handrails. There is enough space for the use and storage of mobility aids.</p> <p>Equipment is maintained in safe working order. Medical equipment is calibrated as required and electrical</p>

<p>for their purpose.</p>		<p>equipment has the required electrical checks. An equipment register is maintained which ensures that all equipment is checked on the due date. The required equipment is available as required to maintain the safe and comfort needs of the residents, for example reclining chairs, hoists and electric beds. These were all sighted to be in good working order.</p> <p>External areas have safe access with paved paths, seating and shelter. Residents/family satisfaction surveys and interviews confirmed general satisfaction with the environment.</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>	<p>FA</p>	<p>There is an approved evacuation scheme. There is evidence in staff training records that fire and evacuation training is conducted regularly as required. Staff attendance at evacuation training is monitored.</p> <p>There have been no changes to the building since the last audit or fire drill (26 October 2018).</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>	<p>FA</p>	<p>The infection surveillance programme is appropriate for the size and complexity of the organisation. Infection data is collected, monitored and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors and action plans are instigated. Staff interviewed reported that they are informed of infection rates at monthly staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed to combat the infection.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. Restraint is part of orientation and training is provided annually or as necessary. Staff completed a restraint competency online and attended a challenging behaviour training. The quality manager monitors all online trainings. Staff meeting minutes evidenced that updates on restraint use and statistics is provided.</p> <p>A restraint register was in place. On the day of the audit, 19 residents were using restraints and three residents were using enablers, which were least restrictive and used voluntarily at their request. Approved restraints and</p>

		enablers include bed rails, recliner chairs, low low beds and lap belts. The assessment, approval, monitoring and review process is the same for both restraints and enablers.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</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>Residents receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. The service uses a pre-packed medication system and medicines are supplied by the contracted pharmacy. All medication packs are checked by the nursing team on delivery against medication charts every two weeks. Medicines in stock are checked every month, any expired medicines are returned to the pharmacy promptly. The service does not stock any vaccines. GP conducts three monthly reviews of medication charts.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and all medications are stored appropriately. Medication is safely stored in locked cupboards and drug trolley. There were no expired medications on site. Documenting (PRN) medicines outcomes</p>	<p>Medication charts reviewed did not have documented evidence of the effectiveness of PRN medication administered.</p>	<p>Provide evidence that the effectiveness of PRN medication administered is documented after use.</p> <p>90 days</p>

		could be improved.		
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Initial admission assessments are completed in a timely manner and resident care plans are completed within three weeks of admission along with interRAI assessments. The nursing team develop residents' care plans and all sampled care plans were reviewed and evaluated six monthly. Where changes had been identified in the residents' condition, acute care plans were completed in a timely manner to reflect residents' current needs. Care plans were not being evaluated in conjunction with interRAI assessments.</p>	<p>Not all care plans were reviewed or evaluated in conjunction with interRAI assessments.</p>	<p>Provide evidence that care plans are evaluated or reviewed in conjunction with interRAI assessments.</p> <p>180 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.