

CHT Healthcare Trust - Highfield Home and Hospital

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: CHT Healthcare Trust

Premises audited:

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric);
Dementia care

Dates of audit: Start date: 24 June 2019 End date: 25 June 2019

Proposed changes to current services (if any): The service has changed its name from CHT Highfield to CHT Te Awamutu

Total beds occupied across all premises included in the audit on the first day of the audit: 58

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

CHT Te Awamutu Home and Hospital is part of the CHT group of facilities (originally named CHT Highfield). The facility is purpose-built, providing three levels of care (hospital – geriatric/medical, rest home and dementia) for up to 60 residents. On the day of audit there were 58 residents. The residents and relatives spoke positively about the care provided.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is a registered nurse who was previously the clinical manager and works full time. She has been in the position for a month. She is supported by a clinical coordinator and a supportive regional manager.

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

One of the two shortfalls identified as part of the previous audit has been addressed. This was around care plan interventions. The previous shortfall around implementation of care continues. This audit has identified one additional area requiring improvement around medication management.

Consumer rights

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

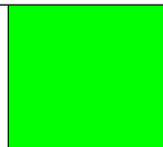


Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. There is a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

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

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and caregivers responsible for the administration of medicines complete education and medication competencies. Medication charts are reviewed three monthly by the general practitioner.

The activities coordinator and staff implement the activity programme to meet the individual needs, preferences and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

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.

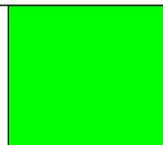


Standards applicable to this service fully attained.

The building holds a current warrant of fitness. All internal and external areas are safe and well maintained. Fixtures, fittings and flooring are appropriate.

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 policies and procedures on safe restraint use and enablers. A registered nurse/quality and risk coordinator is the restraint coordinator. On the day of the audit, there was one resident with restraints in use and no residents with enablers. Staff receive training around restraint and challenging behaviours.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (RN) is responsible for coordinating education and training for staff. The infection control coordinator has completed annual external training. There is a suite of infection control policies and guidelines to support practice. The infection control coordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility.

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	15	0	0	2	0	0
Criteria	0	41	0	0	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>There is a complaints policy/procedure in place and the complaints process is provided to residents and relatives on entry to the service, complaints forms are available to residents and relatives. A record of all complaints is maintained on the on-line complaint register. Paper-based copies of all complaints are held on file. The facility manager manages complaints.</p> <p>There were four complaints recorded. The complaints/concerns have been managed in line with Right 10 of the Code. A review of complaints documentation evidenced resolution of the complaints to the satisfaction of the complainants. Residents (one rest home and three hospital) and family members advised that they are aware of the complaint's procedure. Discussion around concerns, complaints and compliments are evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The facility manager and clinical coordinator confirmed family are kept informed. Accident/incident forms reviewed document that relatives have been notified of the incident. Relatives (four hospital and two with family in the secure unit) stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and resident meetings</p> <p>Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Residents</p>

<p>provide an environment conducive to effective communication.</p>		<p>and relatives receive newsletters.</p> <p>Residents and family are informed prior to entry of the scope of services and any items they have to pay for that is not covered by the agreement. An interpreter service is available if required.</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>CHT Te Awamutu Home and Hospital is part of the CHT group of facilities. The service has very recently changed its name from CHT Highfield to CHT Te Awamutu. HealthCERT have been informed.</p> <p>The building is a purpose-built facility providing three levels of care (hospital – geriatric/medical, rest home and dementia) for up to 60 residents. On the day of audit there were 58 residents. There were 30 hospital and 9 rest home level residents in the 40-bed dual-purpose unit and 19 residents in the 20-bed secure dementia unit. All residents were under the age-related residential care services agreement.</p> <p>The service has a business plan, which is reviewed annually. The business plan identifies the purpose, values and scope of the business. There are quality goals, which have been reviewed regularly and key performance indicators to measure service performance against goals. The facility manager has been in the role for a month and was the clinical coordinator prior to this role. The manager is supported by a clinical coordinator (registered nurse), with a background in aged care. An area manager with significant experience in elderly care provides oversight and support for the new management team.</p> <p>The manager has completed at least eight hours of professional development.</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>CHT Te Awamutu continues to implement the CHT quality and risk programme.</p> <p>There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three healthcare assistants, one registered nurse, one cook, one diversional therapist and the head cook) confirmed they are made aware of any new/reviewed policies. There are sufficient clinical policies/procedures to support hospital level care.</p> <p>The area manager and facility manager meet weekly to discuss quality data, and service and operational issues.</p> <p>The service continues to implement quality teams to act as champions for specific areas such as; weight management, falls minimisation, wound care, restraint, infection control and continence. Staff interviewed (three registered nurses, three healthcare assistants, a cook, activities person and maintenance person) were either part of, or aware of the quality teams.</p> <p>The service enters all quality, accident/incident and infection control data onto a software data base. Monthly collation includes data comparison and trends. These are reviewed by head office and the service.</p>

		<p>Facility meetings held include: monthly staff meetings, monthly RN/ quality meetings and unit meetings. Staff focus meetings were also documented as needed. Meetings minutes sighted evidenced there is discussion around quality data including complaints, compliments, health and safety, accident/incident, infection control, internal audits and survey results. The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>The area manager undertakes six monthly full-service internal audits that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off. Additional audits are also documented such as; wound care audits, restraint audits and care plan audits. The service has also implemented monthly medication audits.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice. There is a current hazard register. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has detailed emergency plans covering all types of emergency situations and staff receive ongoing training around this.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>The service collects incident and accident data on the computer software, which are collated monthly and are discussed at the staff meetings, quality and health and safety meetings.</p> <p>Ten incident forms were reviewed. All incident forms identified a timely RN assessment of the resident and corrective actions to minimise resident risk. Neurological observations had been completed for unwitnessed falls and any known head injury. The next of kin had been notified for all required incidents/accidents. The healthcare assistants interviewed could discuss the incident reporting process. The clinical coordinator collects incident forms, investigates and reviews, and implements corrective actions as required.</p> <p>The facility manager interviewed, could describe situations that would require reporting to relevant authorities. There have been no reports to the Ministry of Health.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	FA	<p>There are human resources policies to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Five staff files were reviewed (two RNs and three HCAs). All files contained relevant employment documentation including orientations. Three HCAs interviewed all agreed that they had received a comprehensive education. Training records document that all compulsory training has been provided, with good staff attendance. Registered nurses and healthcare assistants have access to external training, which</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>includes clinical education relevant to medical conditions such as the palliative care course. Four RNs are interRAI competent. Staff complete competencies relevant to their roles.</p> <p>Of the nine caregivers working in the dementia unit, six have completed the dementia unit standards, and three are in the process, these three have been employed less than 18 months. All RNs have a current first aid certificate.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>Policy is in place to determine staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. The manager and assistant clinical coordinator are on duty during the day Monday to Friday. Both share the on-call requirement for clinical concerns.</p> <p>The RN cover is provided for an RN for each shift, seven days a week, plus an additional RN from midday to 8.00 pm.</p> <p>Healthcare assistants are staffed according to units;</p> <p>There are four wings; Koru one has seven hospital and three rest home residents, Koru two has eight hospital and one rest home resident, Mana three has seven hospital and three rest home residents and Mana four has eight hospital and two rest home residents. Each wing has the same staffing of; AM one long and one short shift, PM one long and one short shift. There are two healthcare assistants over the four wings at night.</p> <p>Dementia (two wings; 19 residents) the clinical coordinator assists in the AM and undertakes the medication rounds. For the AM and the PM each has one long-shift and one short-shift HCA and one HCA for the night shift.</p> <p>A review of rosters evidences that unplanned leave is covered. HCA interviewed stated that management work very hard to cover all shifts as needed.</p> <p>Residents and relatives stated there are adequate staff on duty at all times. Staff stated they feel supported by the management team who respond quickly to afterhours calls.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-administering on the day of audit.</p> <p>The facility uses a four-week robotic sachets system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses administer medications in the hospital, rest home and dementia care unit. Medication competencies are updated annually, and staff attend annual education. Registered nurses have syringe driver training completed by the hospice. The medication fridge temperature is</p>

<p>that complies with current legislative requirements and safe practice guidelines.</p>		<p>checked daily. In the dementia unit, not all medication was identified with the resident's name and one resident was documented as having been given covert medication. This was not documented in the care plan, and there was no evidence of GP approval or family consultation.</p> <p>Registered nurses use an electronic medication management system and sign for the administration of medications. Ten medication charts were reviewed. Medications have been reviewed at least three monthly by the GP. Photo ID and allergy status are recorded. 'As required' medications have indications for use charted.</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>All meals are cooked on site. The kitchen unit manager oversees the procurement of the food and management of the kitchen. The kitchen was observed to be clean and well organised and a food control plan approved (expiring April 2020). Special equipment such as lipped plates is available. On the day of audit, meals were observed to be well presented. There is a kitchen manual and a range of policies and procedures to safely manage the kitchen and meal services. Audits are implemented to monitor performance. Kitchen fridge and freezer temperatures are monitored and recorded daily. Food temperatures are checked at all meals. These are all within safe limits. The residents have a nutritional profile developed on admission, which identifies dietary requirements and likes and dislikes. This is reviewed six monthly as part of the care plan review. Changes to residents' dietary needs have been communicated to the kitchen. Special diets and likes and dislikes are noted on a kitchen whiteboard. The four-weekly seasonal menu cycle is written and approved by an external dietitian. All resident/families interviewed are happy with the meals. Additional snacks are available at all times in the dementia unit.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>The five resident files reviewed identified that care plans were resident-focussed, and most care interventions were included as part of the plan. Care plans reviewed evidence multidisciplinary involvement in the care of the resident. The documentation of blood sugar monitoring, including upper and lower limits, care interventions for constipation and the risks associated with restraint were documented as required in the care plans reviewed. This is an improvement from the previous audit, however the care and management of behaviours that challenge was not well documented.</p> <p>Short-term care plans (STCPs) are in use for changes in health status. STCPs reviewed had been evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan if an ongoing problem. There is evidence of service integration with documented input from a range of specialist care professionals including: the podiatrist, physiotherapist, dietitian and mental health care team for older people. The care staff advised that the care plans are easy to follow.</p>
<p>Standard 1.3.6: Service</p>	<p>FA</p>	<p>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs</p>

<p>Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>		<p>changed. The nurse practitioner interviewed was complimentary of the service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned. Wounds included; one pressure injury, ulcers and skin tears.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs and wounds. All monitoring requirements including neurological observations had been documented as required. This is an improvement from the previous audit. Behaviour charts are available for any residents that exhibit challenging behaviours.</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>There is one activity coordinator who covers five days a week who leads all activities, with caregivers providing some of the activities. The dementia unit has a dedicated activities programme which is facilitated by the activity coordinator and caregivers. The dementia unit residents can also join in the hospital and rest home activities. On the days of audit residents were observed participating in activities.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice of a variety of activities in which to participate. These include (but are not limited to) exercises, walks outside, crafts, games, quizzes, sausage sizzles, the stroke club, inter-home games and bingo.</p> <p>Those residents who prefer to stay in their room have one-on-one visits to check if there is anything they need and to have a chat.</p> <p>There are van outings and the service hire a van as needed. There are regular entertainers visiting the facility. Special events like birthdays, Easter, Mothers' Day and Anzac Day are celebrated. There are visiting community groups such as choirs and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career and family. Activity plans are evaluated at least six monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were positive about the activity programme</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>The registered nurses evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term nursing care plan has been evaluated at least six-monthly or earlier if there was a change in health status. There was at least a three-monthly review by the GP. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.</p>

comprehensive and timely manner.		
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a building warrant of fitness which expires May 2020. There is a comprehensive planned maintenance programme in place. Reactive and preventative maintenance occurs.</p> <p>Electrical equipment has been tested and tagged. All hoists and scales have been checked and tagged. Hot water temperatures have been monitored randomly in resident areas and are within the acceptable range. The communal lounges and hallways are carpeted. The utility areas such as the kitchen, laundry and sluice rooms have vinyl flooring. Residents' rooms are carpeted and ensembles and communal showers and toilets have nonslip vinyl flooring. All halls have safety rails and promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas, courtyards and gardens are well maintained. All courtyards have attractive features and are easily accessible to residents. The dementia unit has a walking pathway, gardens and raised garden beds. All outdoor areas have some seating and shade. There is safe access to all communal areas.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The infection control coordinator/RN oversees infection surveillance for the service. Surveillance is an integral part of the infection control programme and is described in CHT's infection control manual. Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends and analysis of infection events, outcomes and actions are discussed at the combined quality/health and safety and infection control meetings. Results from laboratory tests are available monthly. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures on restraint minimisation and safe practice. Policy includes guidelines and definitions for use of enablers and restraint. On the day of the audit there was one resident with restraints in use (lap belts and a fall out chair) and no enablers in use.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Moderate</p>	<p>The service has policies and procedures in place to guide staff around the safe management, prescribing and administration of medications.</p>	<p>(i). Not all medications in the dementia unit were labelled with the resident’s name.</p> <p>(ii). The progress notes for one resident in the dementia unit documented that covert medications were given. There was no documented GP approval or family/EPOA consultation.</p>	<p>(i). Ensure that resident’s medication is clearly labelled with their name.</p> <p>(ii). Ensure that medication administration complies with the Code of Rights.</p> <p>30 days</p>

<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>Five resident files were reviewed; two hospital level, two dementia care and one rest home. All residents had a care plan documented. Staff interviewed were knowledgeable regarding resident care needs. The management of behaviours that challenge was not well documented.</p>	<p>One hospital and one dementia level resident's file included that the residents' exhibited behaviours that challenge, however the strategies to manage the environment, resident triggers and management of the behaviour were not well documented.</p>	<p>To ensure that all resident care plans include management strategies to manage behaviours that challenge.</p> <p>90 days</p>
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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.