

Trinity Home and Hospital Limited - Trinity Home & Hospital

Introduction

This report records the results of a Certification 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:	Trinity Home and Hospital Limited
Premises audited:	Trinity Home & Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 29 August 2019 End date: 30 August 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:	74

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

Trinity Home and Hospital Ltd (Trinity) is owned by a charitable trust and managed by a board of directors at governance level. A general manager (GA) is responsible for the management of the facility and is supported by a clinical manager, clinical lead and resource manager. The service provides rest home, hospital medical and geriatric and secure dementia care services for up to 78 residents. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, contracted allied health providers and a general practitioner.

Areas identified as requiring improvement relate to quality improvement, first aid certificates and 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.
--	--	--

Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There is no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively

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.		Some standards applicable to this service partially attained and of low risk.
---	--	---

The Trinity board is the governing body and is responsible for the service provided at this facility.

Business, quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system include collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and are current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people

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>
---	--	---

Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

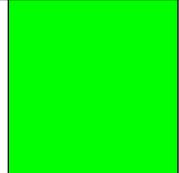
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so. Medication reviews are conducted by the GP three monthly or if required.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals. Snacks are available if needed on a 24-hour period.

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 facility meets the needs of residents and is clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

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.

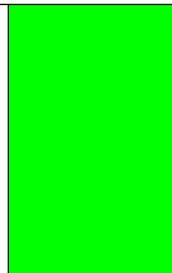


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. Three enablers and two restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Use of enablers is voluntary in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes. There is environmental restraint in the dementia unit and residents were able to freely go in and out of the unit into the surrounding secure garden.

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 prevention and control programme, led by a trained infection control nurse, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and 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	47	0	2	1	0	0
Criteria	0	96	0	2	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
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 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Trinity has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form.</p> <p>Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record.</p> <p>Staff were observed to gain consent for day to day care.</p>

Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Posters and brochures related to the Advocacy Service were displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. The Service has arranged for the local advocacy agency to speak to all residents.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. Links are maintained with the community with the trust providing a day care service for the community. The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that three complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans show any required follow up and improvements have been made where possible. Apology letters were sighted, there was also evidence of advocacy involvement in complaints records sampled and family notifications. Complaints are a standing agenda item for staff, management and board meetings. The GM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. There have been no complaints received from external sources since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through on site education sessions and discussions with staff. The Code is displayed together with information on advocacy services,

Consumers are informed of their rights.		how to make a complaint and feedback forms
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room.</p> <p>Residents are encouraged to maintain their independence by participation in activities of their choice. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has residents who identify as Māori. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The diversional therapist completes a cultural assessment on admission, this links to the residents' care plan.</p> <p>The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents interviewed reported that staff acknowledge and respect their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed. The resident satisfaction survey and resident meeting minutes confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have records of completion of the required training on professional boundaries. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, free monthly podiatry treatment and visit to the hairdresser.</p> <p>The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included the introduction of “bucket list” discussions for all residents, this may include the opportunity for a resident to travel.</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>Residents and family members stated they were kept well informed about any changes to their/their relative’s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents’ records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff know how to access interpreter services, although reported this was rarely required due to all residents being able to speak English.</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 strategic and business plans, which are reviewed annually by the board, outline the purpose, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. This includes the plan to expand current services including the development of a retirement village located behind the current facility.</p> <p>A sample of monthly reports to the board of directors showed adequate information to monitor</p>

		<p>performance is reported including financial performance, KPI's (such as skin tears, falls) and other emerging risks and issues. The GM attends the meetings in the role of secretary.</p> <p>The service is managed by a GM who holds relevant qualifications and has been in the role for 12 years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The GM confirms knowledge of the sector, regulatory and reporting requirements and maintains currency through attending liaison meetings with the DHB. The GM is supported by an acting GM who is on a short-term contract to cover the GM's recent long-term sick leave. The acting GM has the delegated management and clinical responsibilities. The resource manager provides managerial support. Four registered nurses have interRAI competencies.</p> <p>The service holds contracts with the DHB for rest home, secure dementia, hospital – medical/geriatric and respite care. On the day of audit there were 74 beds occupied consisting of nine rest home, 24 secure dementia, three respite and 38 hospital level residents. There were two residents under the respite contract and one private paying respite care resident at time of audit. There is a total of 19 swing beds that can be used for rest home or hospital level care. An additional four beds are allocated for the dementia care service for respite care if needed. There were no residents under the age of 65 years.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the GM is absent, the acting GM carries out all the required duties under delegated authority. The clinical management is overseen by a clinical manager and clinical lead who are experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work well.</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>	PA Low	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including restraint minimization and infection prevention and control. The hazard and risk registers are current.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the board, management team meeting meetings and staff meetings. Staff reported their involvement in quality and risk management activities through assisting with internal audit activities. Relevant corrective actions are</p>

		<p>developed and implemented to address any shortfalls. A quality improvement register is maintained, this documents the issue identified, action plan and outcomes, however evaluation of improvements made to ensure they are effective is not completed. This is identified as an area requiring improvement.</p> <p>Resident and family satisfaction surveys are completed annually. The most recent survey showed although all residents and family were sent a copy of the survey there is only a small number returned. The staff assist residents to complete the survey when requested. The survey indicated that a number of the residents and family reported missing items of clothing. The facility reported all missing items of clothing are placed in a designated area and family are requested to view.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The GM described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</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>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported at board and staff meetings. Staff meetings sighted show discussion occurs in relation to any trends identified and improvements made.</p> <p>The GM described essential notification reporting requirements. One notification made to the coroner's inquest is closed. The clinical manager reported there have been no significant infections since the previous audit.</p> <p>As part of the pre-audit, feedback was sought from the DHB and no issues were raised.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	PA Low	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three-month period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Staff reported that the orientation process prepared them well for their role and included a “buddy” through the initial orientation period.</p> <p>There are eight registered nurses (RN) employed to cover the services. The RN’s have competencies to be completed specifically for their role including management of nursing care and inter-professional health care. There are four trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments</p> <p>Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider’s agreement with the DHB. A staff member is the internal assessor for the programme. Staff working in the dementia care area have either completed or are enrolled in the required education.</p> <p>Staff reported that the annual performance appraisal provides an opportunity to discuss individual training needs, supervision requirements and review competencies. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>An improvement is required in ensuring that all staff allocated to drive the facility van have current first aid certificates.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents.</p> <p>Staffing is a combination of management, registered nurses, care givers, administration and household staff. The largest group of employees is care giver staff with a total of 53.</p> <p>An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current cardiopulmonary</p>

		certificate and there is 24 hour/seven days a week (24//7) RN coverage in the hospital.
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable. Staff are required to write a progress note during the shift, with additional entries if there has been a change or specific event.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local health board's Needs Assessment and Service Coordination (NASC) team. Prospective residents and/or their families who visit the facility prior to admission are provided with written information about the service and the admission process. The service brochure has adequate information on the services provide by the service. The organisation seeks updated information from NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's transfer form to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Referral records were sighted in sampled files. There is a transfer or discharge policy that guides staff on the management of transfers and discharges. Interviewed family</p>

		reported being kept well informed during the transfer of their relative.
<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 medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system and paper-based system was observed on the day of audit. The staff observed administering medication demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Current medication administration competencies were sighted in the staff files.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check medications against the prescription. Clinical pharmacist input is provided on request.</p> <p>There were residents who self-administer medications at the time of audit and appropriate processes are in place to ensure this is managed in a safe manner. Appropriate medication self-administration assessments were completed and reviewed in a timely manner. Medication self-administration policy is in place to guide staff as required.</p> <p>Medication errors are followed up and actions implemented as required.</p> <p>An improvement is required to ensure that controlled drugs are recorded accurately, crushed medication is authorised by the GP and prescription of pro renata (PRN) medicines complies with medication guidelines.</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 two cooks and kitchen staff and is in line with recognised nutritional guidelines for older people. The menu follows a six weeks cycle and has been reviewed by a qualified dietitian within the last two years.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food control plan. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have completed safe food handling qualifications, with kitchen staff completing relevant food handling training.</p> <p>Nutritional assessments are completed for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified</p>

		<p>texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure dementia unit have access to food and fluids to meet their nutritional needs in a 24-hour period. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Interviewed residents and family reported satisfaction with meals provided. Alternative meals are provided per request by residents. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided. Meals were served in portion sizes required by residents and extra food was provided as requested as observed on the days of the audit.</p> <p>The kitchen was clean, and pantry had adequate food supplies for emergency situations if required.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>If a referral is received but the consumer does not meet the entry criteria or there is currently no vacancy, the consumer and family are supported to find an alternative appropriate care. The reason for decline is explained to the consumer and/or family. Immediate risk to the consumer and/or family is managed by the organisation where appropriate to ensure safety. Examples of this occurring were discussed with the clinical manager.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening, and services own assessment form as a means to identify any deficits and to inform care planning. Other healthcare providers including the physiotherapist, diversional therapists and caregivers are involved in the assessment process. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the interRAI trained nurses within three weeks of admission. Interviewed residents and families confirmed their involvement in the assessment process.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidence service integration with progress notes, activities notes, medical and</p>

		allied health professionals' notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans. All reviewed care plans were completed in a timely manner.
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The interviewed GP confirmed that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. Interviewed caregivers confirmed that care was provided as outlined in the documentation and that they have access to residents' care plans to guide service provision. A range of equipment and resources was available, suited to the level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy. There is a weekly planner that is provided to each resident and a monthly planner that is posted on notice boards around the service. Monthly themes and special celebrations are included in the activities plan.</p> <p>A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated when there are changes in resident's ability and as part of the formal six monthly interRAI assessments and care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. A Health and Disability Commissioner (HDC) advocate visits once a year and provides one on one talks with residents. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents and family interviewed confirmed they find the programme satisfactory.</p> <p>Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living with dementia. Activities are offered at times when residents are most physically active and/or restless. This includes walks, sing along, van outings, musical DVD's and one on one conversations.</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 progress notes by the caregivers. If any change is noted, it is reported to the RN. RNs document in the progress notes at least weekly and more frequently as determined by the resident's condition.</p> <p>Formal care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for chest infections, urinary tract infections, weight issues and wounds. Unresolved short-term problems are added to the long-term care plans for ongoing monitoring. Residents and families/whānau interviewed their involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a 'house doctor', residents are given a choice to use another medical practitioner. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The facility is purpose built. A current building warrant of fitness (dated April 2019) is publicly displayed. External areas are safely maintained and are appropriate to the resident groups and setting. Residents in the dementia unit can safely access a secure external area.</p> <p>Maintenance is completed in an on-going manner by specialist contractors and on a need to need basis. An inspection of the facility confirmed that all maintenance concerns were being addressed.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with staff and observation of the environment.</p> <p>All hazards are identified and monitored accordingly, with any concerns reported to management and discussed at staff and board meetings. Routine environment audits ensure the environment is hazard free, that residents are safe, and independence is promoted.</p> <p>Residents and staff interviewed confirmed they know the processes they should follow if any repairs or maintenance is required, any requests are appropriately actioned and that they are happy with the environment.</p> <p>There is a pest control programme in place.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes shared bathrooms, ensuites and separate toilets. Each resident room has a handbasin. Equipment and accessories are available to promote resident independence. Hot water temperatures are routinely monitored at the point of use.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Separate communal areas are available in the rest home, hospital and dementia areas for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. A chapel is available that residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p> <p>There are no restrictions regarding visiting hours and family interviewed confirming that they are made welcome at any time. Entry to the dementia unit is gained by pushing the external entry button.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Policies and procedures regarding all cleaning and laundry services are documented and readily available to staff. These provide clear directions regarding the required tasks, safety and infection prevention and control requirements.</p> <p>There is a designated laundry which is located internally on a lower level. The laundry is not accessible to residents. The closed-circuit chemical safety system is monitored by an external contractor. Chemical safety training has been provided in the in-service training programme. The laundry has clearly defined areas for clean and dirty linen.</p> <p>Cleaning is provided by cleaning staff and carers. One cleaning trolley is used across the facility. There is a secure cupboard in the dementia unit for storing any cleaning products. A cleaning schedule, that includes curtains and drapes ensures all areas are cleaned in a timely manner.</p> <p>Residents and family interviewed reported the rooms were kept clean.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency.</p> <p>All staff receive training on emergency management and evacuation procedures. There is an approved fire evacuation plan. Fire systems and equipment are checked annually during the building warrant of fitness inspection. Evacuation drills are completed every six months. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water,</p>

		<p>blankets, mobile phones and gas BBQ's were sighted. Water storage tanks are located around the complex, and there is a generator on site. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time, staff ensure the facility is well secured each evening.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There is thermostatically controlled heating throughout the facility and temperatures can be monitored. The facility has plenty of natural light and ventilation. Each bedroom has an external window of normal proportions. There are no residents or staff that smoke on the premises.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialists. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated infection control nurse, whose role and responsibilities are defined in a job description. The signed job description is in place and was sighted in the infection control folder. Infection control matters, including surveillance results, are reported monthly to the general manager, clinical manager, and tabled at the quality/risk committee meetings that include representatives from all departments.</p> <p>Signage at the main entrance to the facility requests anyone who has flu symptoms or any other communicable infection, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Interviewed staff understood these responsibilities. Residents who have infectious conditions are isolated in their rooms until the infection is resolved to minimise spread of infection. Personal protective equipment was used as required.</p>
<p>Standard 3.2: Implementing the infection control programme</p>	FA	<p>The infection control nurse has appropriate skills, knowledge and qualifications for the role, and has been in this role for two months. The infection control nurse has completed a certificate in infection prevention and control as verified in training records sighted. Additional</p>

<p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>		<p>support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection control nurse confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on the days of the audit.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed in within the past year and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing facilities and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>Staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified infection control personnel from the local DHB. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell, increasing fluids during hot weather.</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</p>	<p>FA</p>	<p>Trinity home and hospital's infection surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract infections. The infection control nurse reviews all reported infections, and these are documented. New infections and any required management plans are discussed at handover, to ensure early intervention occurs as reported</p>

programme.		<p>by interviewed staff and reviewed residents' records.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Comparisons against previous months were completed. There were no infection outbreaks reported since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<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 and demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities.</p> <p>On the day of audit, two residents were using restraints and three residents were using enablers, which were the least restrictive and used voluntarily at their request. The approved restraints for the organisation are t-belts, bedrails, ultra-low beds and specialised chairs e.g. fall out chairs. The two residents using restraints use t-belts when they go on trips only either out in the van outings or out with family to prevent them from falling out of the seat.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, files reviewed, and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval group made up of the clinical manager, RNs and the GP are responsible for the approval of the use of restraints and the restraint processes. It was evident from review of restraint approval group meeting minutes, residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed. The clinical manager is the restraint coordinator and has a job description in place with responsibilities clearly outlined.</p> <p>The resident, family/whānau/EPOA were involved in the decision making and evidence was sighted in the reviewed residents' files. Use of a restraint or an enabler was documented in the residents' care plans that were reviewed.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment</p>	FA	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement, and input from the resident's family/whānau/EPOA. The interviewed restraint</p>

<p>of consumers is undertaken, where indicated, in relation to use of restraint.</p>		<p>coordinator described the documented process. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint and enablers.</p>
<p>Standard 2.2.3: Safe Restraint Use Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff e.g., the use of sensor mats and ultra-low beds.</p> <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each restraint approval group meeting. The register was reviewed and contained all residents currently using a restraints and enablers and sufficient information to provide an auditable record.</p> <p>Staff have received training in restraint use, challenging behaviours and de-escalation techniques. Interviewed staff understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Restraint use is reviewed and evaluated during care plan and interRAI reviews, three monthly restraint evaluations and at the restraint approval group meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, documentation sighted in records reviewed.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly restraint meetings and reports are completed, and individual use of restraint use is reported to the quality and staff meetings. Minutes of meeting reviewed confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of</p>

		restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit that is carried out also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated.
--	--	--

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 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality data is collected such as incidents, and audit results. Action plans are opened if required and outcomes of actions completed documented. There is evidence that improvements are made in an ongoing manner, however evaluation to indicate improvements are effective is not completed.	Quality improvement data is collected and analysed, however the data is not evaluated to indicate improvements made are effective.	When quality improvements are made in response to incidents, actions plans are evaluated to indicate improvements are effective. 180 days
Criterion 1.2.7.2	PA Low	The facility resident van is used for resident outings. Four staff are allocated	Staff allocated	Ensure all

<p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>		<p>the responsibility of driving the van. The staff have current cardiopulmonary certificates; however, they do not have a current first aid certificate.</p>	<p>to drive residents in the facility van do not have a current first aid certificate.</p>	<p>staff who drive residents in the facility van have a current first aid certificate.</p> <p>180 days</p>
<p>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.</p>	<p>PA Moderate</p>	<p>The GP's uses electronic system and paper-based systems when prescribing of medicines. Reconciliation of medicines is completed by RN's when received from the pharmacy. Two staff with medication administration competencies check and record controlled drugs received from the pharmacy. On the days of the audit, there was one resident who had medication crushed. There is a medication crushing policy in place with clear guidelines for staff. The records of temperatures for the medicine fridge reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines. The required three-monthly GP review is consistently recorded on the medicine charts. 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. An improvement is required to ensure that accurate documentation of controlled drugs is completed, crushed medication is authorised by the GP, PRN medicines are prescribed as per medication guidelines, temperature of the medication rooms are monitored, and expired medication is removed from stock in use.</p>	<p>Medication management does not meet legislative requirements or current best practice:</p> <ul style="list-style-type: none"> • Medication held in stock had passed the best before date. • Prescribed medication for oral administration was crushed prior to administration without the GP's authority on prescription chart. 	<p>Ensure all medication management meets legislative requirements.</p> <p>90 days</p>

			<ul style="list-style-type: none"> • Documentation in the Controlled drug register was incorrect. • No indications for use and/or maximum dose on prescribed PRN medications. • Temperature of the medication rooms currently not monitored for temperature control. 	
--	--	--	---	--

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.