# Pinehaven Cottage Limited - Pinehaven Cottage

## 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 The DAA Group 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Pinehaven Cottage Limited

**Premises audited:** Pinehaven Cottage

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 14 November 2019 End date: 14 November 2019

**Proposed changes to current services (if any):** The reconfiguration for one additional dementia level bed within the secure unit – total dementia level beds 23. Original rest home bed used for office space reinstated back to rest home level care – total rest home beds 12. Total number of beds within the facility remain at 35. A new nurses station is now within the rest home wing.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 34

# Executive summary of the audit

## Introduction

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

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

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

**Key to the indicators**

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

Pinehaven Cottage provides rest home and secure dementia care services for up to 35 residents. The service is operated by Pinehaven Cottage Limited and managed by two managers who share the management roles and a registered nurse who covers the clinical components of service delivery. Residents and families spoke positively about the care provided.

The surveillance audit was conducted against the Health and Disability Services Standards and the service’s contract with the Waitemata District Health Board (WDHB). The audit process included review of policies and procedures, review of residents’ and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

The one area requiring improvement from the previous audit relating to interRAI assessments has been addressed. There is one area requiring improvement identified during this surveillance audit in relation to medication management.

An approved reconfiguration was verified at the time of this surveillance audit and meets all requirements.

## Consumer rights

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

Open communication between staff, residents and families is promoted and was 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.

A complaints register is maintained with complaints resolved promptly and effectively.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The business plan was reviewed and included the goals and values of the organisation. Monitoring of the services provided to the governing body was regular and effective. An experienced and suitably qualified management team manage the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families and those with enduring power of attorney (EPOA). 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 were current and reviewed regularly.

The appointment, orientation and management of staff is based on 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.

## Continuum of service delivery

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

The registered nurse (RN) and general practitioner (GP), assess residents’ needs on admission. The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach. Residents and their family/whanau where appropriate are involved in the care planning process. 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.

Activities provided are appropriate to meet the needs, age and cultures of the residents and the setting of the service. The activities reflected the ordinary patterns of life and included involvement of other representatives and other community groups.

There is a medicine management system in place and medicines are administered by staff who are competent to do so.

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 and drinks are available 24 hourly if needed.

## Safe and appropriate environment

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

There was a current building warrant of fitness displayed at the entrance to the facility.

## Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers and no restraints were in use at the time of the audit. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

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

The infection control coordinator and all staff take the responsibility for surveillance activities and promote surveillance monitoring as part of the quality assurance programme. Surveillance of infections is carried out in accordance with agreed objectives and methods that have been specified in the infection control programme. There have been no infection outbreaks reported since the last audit.

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 16 | 0 | 0 | 1 | 0 | 0 |
| **Criteria** | 0 | 40 | 0 | 0 | 1 | 0 | 0 |

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| --- | --- | --- | --- | --- | --- |
| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| 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, those with enduring power of attorney (EPOA) and families on admission, and those interviewed knew how to do so.  The complaints register reviewed showed that two complaints have been received over the past year and that actions were taken through to an agreed resolution and that time frames were effectively met. Action plans showed any required follow-up and improvements have been made where possible. The manager interviewed was responsible for complaints management and follow-up. All staff interviewed confirmed a sound understanding of the complaint process and what actions were required. There have been no complaints received from external sources since the previous audit. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Residents and family members stated they were kept well informed about any changes to their/their relative’s health status and the outcomes of regular and any urgent medical reviews. This was evident 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 of Health and Disability Services Consumers’ Rights. Interviewed family reported that they are advised of all changes in residents’ health status, incidents and accidents promptly.  Information on interpreter services is accessible to staff through the local District Health Board (DHB), although the interviewed staff reported this was rarely required due to all residents able to speak English and the use of family members. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The business plan for 2019 was reviewed and ten aims were documented for this year to be achieved. The organisation’s values, direction and goals were outlined. A sample of management meeting minutes were reviewed to assess progress and to monitor performance and/or any emerging risks and issues.  The service is managed by four managers. Two managers interviewed job share the day to day management role. Both hold relevant health professional qualifications occupational therapists (OTs) and have been managing services in the aged residential care sector for some years. The two managers interviewed have appropriate skills and knowledge of the sector, regulatory and reporting requirements and maintain currency through attending conferences, DHB seminars and aged residential care association leadership/management study days.  The service holds contracts with the Waitemata District Health Board (WDHB) for rest home, respite and secure dementia level care. Thirty four (34) residents were receiving services under the contract; (23) dementia level care (this includes the reconfiguration of one additional dementia care bed) since the previous audit, and (11) rest home beds of the 12 available. One office has been reconfigured and is now used as a rest home bedroom though it was not occupied on the day of the audit. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of complaints, internal audit activities, management of incidents, monitoring of outcomes, satisfaction surveys and any clinical incidents including infections and challenging behaviours.  Meeting minutes reviewed confirmed regular review and analysis of indicators and that related information was reported and discussed at the quality meetings held monthly and the general staff meetings held regularly every six weeks. Staff reported their involvement in quality and risk management activities through audit activities and staff meetings. Relevant corrective actions are developed and implemented to address any shortfalls. When completed, these are signed off and dated. Resident and family satisfaction surveys are completed annually. The last satisfaction survey was completed in May 2019. The outcomes were mostly positive in relation to the care and staff input and activities were noted to be enjoyed by residents and families.  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 were current. The document control system ensures systematic and a regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.  The manager described the processes for the identification, monitoring, review and reporting of any risks and development of any mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented the requirements. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | Staff complete an incident report form for any adverse events or near miss events and this is given to the registered nurse. The registered nurse completes the relevant sections on the form with an outcome summary and any required actions. Any contributing factors identified are recorded, for example, in relation to communication, resident, policy, procedure, equipment or safety issues. The information is collated by the management team in event reporting and shared at the continuous quality improvement meeting held monthly. The number of incidents are recorded by category and are compared with the previous month. Feedback is provided at the staff meetings, and if needed, earlier at staff handover sessions.  The manager interviewed described essential notification reporting requirements including for pressure injuries, if any. They advised there have been two section 31 notices to HealthCERT since the previous audit; one for recruitment for RN cover and one for a resident who went missing but was found safe and well. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | Human resource management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes reference checks, police vetting for all new staff and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation’s policies are being consistently implemented and records are maintained. All staff have received orientation/induction of all necessary components relevant to their role. Job descriptions were sighted. Staff reported that the orientation process prepared them well for their role. Staff records reviewed showed documentation of completed orientation and a performance review annually.  Continuing education is well planned on an annual and two yearly basis to include all mandatory training requirement and contractual obligations. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the agreement qualifications. Staff working in the secure dementia care area have either completed or are enrolled in the required education. Twelve care staff have completed Level 4 dementia care, five care givers are enrolled and completing level 4 dementia care currently and five care givers only work in the rest home. There is currently one registered nurse who is trained and competent to complete the interRAI assessments. Time is allocated for the RN to complete the interRAI in a timely manner (an RN position has been advertised to cover the current RN for leave) and a section 31 notice had been completed (sighted) in relation to the difficulty experienced in recruiting to this role. Records reviewed demonstrated completion of the required training. Evaluations are recorded after each teaching session. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a documented 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. An afterhours on call roster is in place with staff reporting that 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 were satisfied with the care provided. Observation and review of a four week roster 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 first aid certificate. Management are fully supporting a team leader (senior caregiver/RN overseas trained) to obtain New Zealand registration and also have full assistance of the WDHB for training and advice for this staff member. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | Pinehaven Cottage uses an electronic medication management system. The RN is responsible for conducting annual medication administration training and medication administration competency checks for the caregivers. The RN is responsible for medication reconciliation when medication is received from the pharmacy monthly and when residents are admitted from the community or other health service providers. Medication is stored safely in locked cupboards and medication trolleys.  One caregiver was observed administering medication correctly in a manner that complies with safe medicine management guidelines. The staff observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the electronic prescription chart. Clinical pharmacist input is provided on request.  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 required stock checks and accurate entries.  The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.  Prescribing practices included the prescriber’s signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP reviews were consistently recorded on the electronic medicine chart. Standing orders are not used.  There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner if required. There is an implemented process for the comprehensive analysis of any medication errors.  Evaluation of effectiveness of PRN medication administered was not documented and PRN medications in the drug trolley and medication stock cupboard were expired. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food service is provided on site by two cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four weekly cycle and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.  A diet profile with residents’ food preferences, food allergies, likes and dislikes are completed at the time of the resident’s admission and a copy is provided to the kitchen staff. Special diets and modified textures are provided when required. Regular monitoring of residents’ weights was completed, and nutritional supplements were provided when required. Interviewed residents reported satisfaction with the food provided. Residents are offered alternative food choices when needed. Residents in the secure unit have access to food and fluids to meet their nutritional needs 24 hours of the day. Special equipment to meet resident’s nutritional needs is available.  The kitchen was observed to be clean on the audit day. The pantry was clean and well packed with no food packages on the floor. There was no expired food in stock. There is a food procurement process in place managed by the manager in consultation with the cook. Food, fridge and freezer temperature monitoring records were sighted. Leftover food in the fridge was covered and dated.  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 safety plan and current registration issued by Auckland Council and is line with current legislative requirements. Food, fridge and freezer temperatures, are monitored appropriately and recorded as part of the plan. The cooks have completed relevant food handling training and caregivers who assist in the kitchen have received training on food handling hygiene.  Evidence of resident satisfaction with meals was verified by residents and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documented interventions in the care plans reviewed were individualised, appropriate and adequate to meet residents’ assessed needs and desired outcomes. The interviewed RN and caregivers reported that medical input is sought in a timely manner, that medical orders are followed, and care is implemented promptly. This was verified in the residents’ records reviewed and confirmed by interviewed family and residents. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents’ needs. |
| Standard 1.3.7: Planned Activities  Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | The activities programme is provided by three activities coordinators. One of the three is the manager who has experience as an occupational therapist and oversees the programme.  A social assessment and history were completed 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. Daily activities notes were completed for the residents in the rest home and monthly for the residents in the dementia unit. The resident’s activity needs were evaluated when there was significant change in participation and as part of the formal six-monthly care plan review.  Reviewed activities plans reflected residents’ goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. The activities on the programme included exercises, bowls, bingo, newspaper reading and discussion, bus outings, music therapy, manicure and pampering, walks, birthday celebrations, external entertainers, community visits and puzzles. Residents and families/whānau are involved in evaluating and improving the programme through residents’ meetings and satisfaction surveys. Interviewed residents confirmed they find the programme satisfactory.  Activities for residents in the secure dementia unit are specific to the needs and abilities of the people living with dementia. Twenty-four care plans for the residents in the dementia unit were completed. Activities are offered at times when residents are most physically active and/or restless. This includes walks, pampering, bus outings, music therapy, art and craft. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents, family/whanau if appropriate, and enduring power of attorney, where applicable, are involved in evaluation of care plans. The RN reviews the residents’ care plans six-monthly and earlier when indicated by the resident’s condition. The evaluations indicated the degree of achievement or response to interventions. Where the desired outcome was not achieved, changes were implemented in the care plan to meet the residents’ needs. Short-term care plans sighted were reviewed regularly and closed off when the condition had been resolved. Documentation of the changes were verified in the long-term care plans reviewed. Interviewed residents and family confirmed being involved in the review process and this was verified in the signed care plans reviewed. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness which expires 26 May 2020 was publically displayed. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The reconfiguration of increasing one bed in the secure dementia service and changing an office to a bedroom in the rest home has had no impact on the current fire evacuation plan. The fire evacuation approval letter is dated 06 June 2002 from the New Zealand Fire Service. The last fire drill was held on the 05 May 2019. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control surveillance undertaken is appropriate to the size and complexity of the service as determined by the infection control committee. Monthly infection statistics are collected, collated and analysed by the infection control coordinator. Any infection trends and statistics are documented and discussed with staff in staff meetings and recommendations to assist in infection control reduction and prevention or interventions are put in place, acted upon and evaluated in a timely manner. Standardised definitions are used for the identification and classification of infection events and indicators.  New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Hand hygiene audits are completed annually as confirmed in audit reports sighted. Expert advice is sought as needed through the GP or the local district health board as reported by the interviewed RN.  There has been no infection outbreaks since the last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | 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 registered nurse coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated knowledge and understanding of the organisation’s policies, procedures and practice, the role and the responsibilities. On the day of the audit, no residents were using restraints and no residents were using enablers. The staff interviewed reported that enablers were used following a voluntary request from the resident and that restraint is only used as a last resort when all alternatives have been explored. Meeting minutes were reviewed, residents’ records and interviews with staff occurred. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | The caregivers administer PRN medicines with guidance from the RN. The RN is responsible for completing monthly stock checks. Reasons for the administration of PRN medicines were documented, but the required evaluation of the effectiveness of the ten PRN medicines out of 12 reviewed were not completed.  There were three expired packs of PRN medicines in the trolley and ten in the stock cupboard. | Three expired PRN medication packs were found in the trolley for the stock in use and ten medicines were found in the medication storage cupboard.  Ten out of 12 PRN medicines administered had no evaluation of effectiveness documented. | Provide evidence of evaluation of the effectiveness of PRN medicines administered.  Ensure all expired medicines are removed from the stock in circulation and returned to the pharmacy as required.  90 days |

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

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

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

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

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| No data to display |

End of the report.