

# Maungaturoto Residential Care Limited - Maungaturoto Rest Home

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## 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](#).

The specifics of this audit included:

**Legal entity:** Maungaturoto Residential Care Limited

**Premises audited:** Maungaturoto Rest Home

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

**Dates of audit:** Start date: 1 October 2019 End date: 1 October 2019

**Proposed changes to current services (if any):** A concrete foundation has been laid for a planned reconfiguration of the certified services provided at Maungaturoto Rest Home. HeathCERT have been advised.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 12

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Maungaturoto Rest Home provides rest home and respite level care for up to 16 residents. The service is operated by Maungaturoto Residential Care Limited and managed by a facility manager/registered nurse. Residents and families spoke positively about the care provided.

This unannounced surveillance 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 records, observations and interviews with residents, family members, staff, managers and the general practitioner who covers the service.

The audit has resulted in confirmation that eight of the nine previous areas that required improvement have been effectively addressed. One area requiring improvement in relation to interRAI assessments remains open. The previous improvement required for medication management was closed out, however one new medication management area of improvement was identified.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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At Maungaturoto Rest Home open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required.

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.		Standards applicable to this service fully attained.
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Business and quality and risk management plans include the scope, direction, goals and values of the organisation. Monitoring of the service provided to the governing body was regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system now includes collection and analysis of quality improvement data, identifies any 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 were current and reviewed in a timely manner.

The appointment, orientation and management of staff is based on good practice. Training is provided at orientation for all new staff and is ongoing. Training provided supports service delivery and includes annual performance appraisals being completed for all staff. Staffing levels and skill mix is appropriate for this rest home service.

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach to care delivery. There are policies in place to support assessment, planning, provision of care, evaluation and transfers for residents to safely meet the needs of the residents and contractual requirements.

Residents have interRAI assessments completed and individualised care plans related to this programme. All care plans are evaluated at least six monthly.

The service provides planned activities meeting the needs of the residents as individuals and in group settings.

The onsite kitchen provides and caters for residents with food available 24 hours of the day and specific dietary likes and dislikes accommodated. The service has a four-week rotating menu which has been approved by a registered dietitian. Residents' nutritional requirements are met.

Medication policy identifies current best practice for medication management. Staff who administer medication have completed a medication competency in the last 12 months.

## 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.

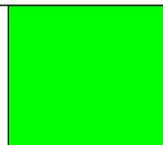


Standards applicable to this service fully attained.

The facility has a current building warrant of fitness which was displayed at reception.

## 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. No enablers and no restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enable processes.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Surveillance for infections is completed every month. Results of surveillance are reviewed to assist in minimising and reducing the risk of infection. The infection surveillance results are reported back to staff and residents, where appropriate, in a timely manner.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	16	0	2	0	0	0
Criteria	0	42	0	2	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints and compliments policy and associated forms meet the requirements of Right 10 of the Code. The policy was reviewed 4 May 2018. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that no complaints had been received since 11 September 2017. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. The facility manager is responsible for complaints management for this organisation.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>Residents and family members interviewed 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 knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English. Appropriate equipment, resources and allied support to assist with communication was evidenced in the resident's long-term care plans, for example, a resident with restricted mobility due to a current leg wound had</p>

conducive to effective communication.		the use of a hand bell when in the main lounge to notify staff when requiring support.
<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>	FA	<p>The business quality risk and management plan which is reviewed annually was reviewed. The quality policy statement and plan outlines the purpose, values, scope, direction and goals of the organisation. The documents described annual and longer term objectives and the associated operational plans. A sample of monthly indicators and reports to the board of directors showed adequate information to monitor performance is reported including any emerging risks or issues that may have arisen. Any specific plans, aims and ambitions for 2019 are updated.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for ten years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager is a registered nurse and confirmed knowledge of the sector, regulatory requirements and maintains currency through ongoing education annually. A registered nurse from the Northland District Health Board (NDHB) visits the facility monthly to provide training and advice. The facility manager is currently training and receiving updates for Concerto the electronic system in place for NDHB.</p> <p>The service holds contracts with NDHB for rest home and respite care aged residential care services. Twelve residents were receiving services under the contract, 10 rest home level care and two residents receiving respite care at the time of audit.</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>	FA	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This plan has been updated 22 May 2018. Routine planned audits are being undertaken which are designed to measure compliance with the plan. This was an area for improvement identified in the previous audit that has been addressed.</p> <p>The facility manager interviewed stated that the trust also has a formal business plan. This plan includes the proposed specialist dementia service (currently the trust is raising additional funds for the building project). HealthCERT has been formally notified of the reconfiguration intention. A letter was sighted from HealthCERT outlining the service's responsibilities for this project.</p> <p>Meeting minutes (documented in a minute book) reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the staff meetings and at the board meetings monthly. Staff reported their involvement in quality and risk management activities. Relevant corrective actions are developed and implemented to address any shortfalls. A review and amendment log is maintained by the facility manager. The corrective action plans are reviewed monthly which cover the area identified for improvement, the improvement plan, who will be responsible and the measurable improvement indicators are documented. This was an area requiring improvement from the previous audit which now meets the standard.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to</p>

		<p>the interRAI Long Term Care Facility (LTCF) assessment tool and processes implemented. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and obsolete documents are removed from the manuals sighted as per policy. This was also an area for improvement identified at the previous audit.</p> <p>The facility manager described the processes for the identification, monitoring, review and reporting of any risks and development of mitigation strategies. The manager is familiar with the health and safety at Work Act (2015) and has implemented requirements. One staff member is the health and safety coordinator but was not available on the day of the audit for interview. The annual hazard review was completed 22 March 2019 and signed off by the health and safety coordinator.</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 incident 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 to the staff meeting and where relevant to the board of trustees at the monthly meetings.</p> <p>The facility manager described essential notification reporting requirements including for pressure injuries. The facility manager advised there have been no notifications of any significant events made to external agencies since the previous audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment</p>	FA	<p>Human resources management policies and procedures are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting with any new staff and validation of qualifications and practising certificates (APCs) where applicable. A sample of records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. 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 showed 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. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the</p>

practice and meet the requirements of legislation.		requirements of the provider's agreement with the NDHB. The facility manager is the onsite assessor for the programme. The RN/facility manager maintains their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
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 clearly documented and implemented policy which determines service provider levels and skill mix to provide safe service delivery. This was an area requiring improvement from the previous audit and has been adequately addressed. The one hospital level resident with a dispensation from HealthCERT has deceased since the last audit. The one other resident who was waiting for an assessment at the time of the previous audit was assessed by the needs assessment service coordinator (NASC) and was transferred to a private hospital for ongoing care and management. The rosters reviewed provided adequate cover for twenty four hours a day seven days a week. Staff were replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate. An after-hours roster is in place with staff reporting that good access to advice is available when needed. Healthcare assistants interviewed stated adequate staff were available to complete the work allocated to them. Residents and family interviewed supported this.
Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	All necessary demographic, personal, clinical and health information was fully completed in the residents' files and medication folder 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. The previous audit identified an area for improvement to ensure that all documents related to residents contain uniquely identifying information. The corrective action is now addressed, and records were available to demonstrate this.  Archived records are held securely on site and are readily retrievable using a cataloguing system.  Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.
Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe	PA Low	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.  A safe system for medicine management using a paper-based system was observed on the day of audit. The staff observed 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

<p>and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>manage.</p> <p>The previous audit identified an area for improvement to ensure that all medication and supporting consumables are dispensed and stored as per best practice medication guidelines and policy. The corrective action is now addressed, and records were available, and practice was observed at the time of the audit to demonstrate this.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks with the facility manager and pharmacist and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices include the prescriber's signature and date recorded on the commencement of medication. The medication chart did not always show evidence of the prescriber's signature for all discontinuation of medicines or have the reason documented for pro re nata (PRN) medicines. The required three-monthly GP review is consistently recorded on the medicine chart. Standing orders are used, were current and complied with guidelines. Vaccines are not stored on site.</p> <p>There were no residents who were self-administering medications at the time of audit.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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 one of four cooks and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, transportation, delivery and disposal comply with current legislation and guidelines. The previous audit identified areas for improvement to ensure that the storage of food complies with current legislation and guidelines. The corrective action is now addressed with records available to demonstrate this.</p> <p>The service operates with an approved food safety plan and registration issued by the Kaipara District Council which expires 14 March 2020. A food verification was completed on the 7 February 2019 and is valid for 18 months. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken safe food handling qualifications.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed.</p>

		<p>The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	PA Low	<p>Information is documented using validated nursing assessment tools such as pain scale, falls risk, skin integrity, nutritional screening and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the facility manager who is a trained interRAI assessors for the facility. Residents and families confirmed their involvement in the assessment process.</p> <p>The previous audit identified an area requiring improvement to ensure that the facility is able to access the interRAI database, that all interRAI assessments are completed to reflect any changes, current needs and outcomes for the resident and their health, and to provide evidence that all residents are assessed at their right level of care. Those requirements have been partially addressed but further improvements are required to ensure that all residents' interRAI assessments and long-term care plans are completed to reflect the current needs for the resident in its entirety.</p>
<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 in progress notes, observations and interviews verified the 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. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is patient centred and excellent. Care staff confirmed that care was provided as directed. 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</p>	FA	<p>The activities programme is provided by an activities co-ordinator (not available at time of audit) who supports residents Monday, Wednesdays and Fridays for three hours a week.</p> <p>A social assessment and history is 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 daily and as part of the formal six-monthly care plan review. It was noted at the time of audit that the activity notice board needs updating to reflect current</p>

requirements are appropriate to their needs, age, culture, and the setting of the service.		<p>photos and activities that the residents are partaking in.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through day to day discussions. Residents interviewed confirmed they find the programme fun.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with 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 and wound management being consistently reviewed, and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes, for example being notified of an incident, outcome of a GP visit and been invited to attend the annual review of their family member.</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>	FA	<p>A current building warrant of fitness expiry 13 July 2020 is publicly displayed. There have been no changes to the fire evacuation plan required. The concrete floor has been laid for the proposed reconfiguration. HealthCERT has been notified of this project which will be completed as and when trust board funds are available.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities,</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes urinary tract infection, respiratory tract infection, skin, wound, eye, gastro enteritis and other infections. The IPC coordinator/facility manager reviews all reported infections, and these were documented. New infections and any required management plan are discussed at handover to ensure early intervention occurs and short-term care plans are developed.</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 graphs, regular staff meetings and at staff</p>

<p>and methods that have been specified in the infection control programme.</p>		<p>handovers. Trends are identified from the past year and this is reported by the facility manager and reported to the board of directors.</p> <p>The facility has had a total of five infections from May 2019 through to and including September 2019. The facility had no infections for the months of May and June 2019. The residents' files reviewed highlighted short term and long-term care planning to reduce and minimise the risk of infection. Care staff interviewed demonstrated knowledge of residents who have a higher risk of infections and the interventions required.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures have been reviewed and updated to meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. This was an area for improvement identified in the previous audit which has been addressed. The facility manager provides support and oversight for enabler and restraint management in the facility and has an understanding of the requirements and responsibilities involved. On the day of the audit no residents were using a restraint or enablers. The register reviewed documented that the last enabler was discontinued 19 June 2019. Restraint is only used as a last resort when all alternatives have been explored. This was evident on review of restraint meeting minutes sighted, residents' records reviewed and from interview with staff.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	The staff knew the residents well and when interviewed could recall the proper procedures required when administering and supporting residents with medication. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement of medicines. Ten residents' files were reviewed, and evidence was sighted to show that the GP reviews were up to date and all the residents had been seen by the GP. Seven residents' medication files reviewed did not have short course medication discontinuation signed off by the GP. Two residents' medication files reviewed did not have the pro re nata (PRN) medications indication for use.	Medication documentation processes were not undertaken in accordance with good practice in relation to documentation of discontinued medication and indication for use of pro re nata (PRN) medication.	<p>To provide evidence that all residents medication charts with short course medication and medication that has been discontinued meets best practice medication guidelines documentation.</p> <p>180 days</p>

<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	<p>PA Low</p>	<p>All residents had an up to date interRAI assessment and long-term care plans. The facility manager/RN and staff interviewed knew the residents well and were able to discuss residents' individual needs and day to day activities of living and interventions required. Residents and family members interviewed stated that they were very happy with the care provided. Not all residents' interRAI assessments and long-term care plans reflected the current needs and interventions for the residents.</p> <p>A resident with a history of falls had this information documented in their long-term care plan and interRAI assessment but the specific interventions in place did not reflect that they were supported by a sensor mat and limb protectors.</p> <p>One resident had a well-documented behaviour monitoring form acknowledging behaviours and outcomes. The long term care plan and interRAI assessment acknowledged that the resident presented with regular behaviours that were challenging; however, the specific behaviours and interventions required to manage, reduce and minimise this behaviour was not evidenced in the residents' long-term care plan or interRAI assessment. The resident had identified in their interRAI that they required supervision with showering, prompting and encouragement, but this information was not documented in their long-term care plan.</p> <p>One resident with a cognitive impairment whom had a history of becoming confused would follow his home routine which involved leaving the facility. The family and staff implemented a daily intervention to reduce this wandering from occurring which was effective; however, this activity was not documented in the long-term care plan or interRAI assessment.</p>	<p>Three of five residents' files reviewed did not always have the interventions to reflect the current needs and outcomes for the residents in their long-term care plans and/or interRAI assessments.</p>	<p>Provide evidence that all interRAI assessments and long-term care plans reflect the current needs and interventions required for the residents.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.