Experion Care NZ Limited - Wensley House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Experion Care NZ Limited
Premises audited:	Wensley House
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 October 2020 End date: 30 October 2020

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: 30

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

Wensley House provides rest home level care for up to 30 residents. The service is operated by Experion Care NZ Limited and managed by a general manager and a clinical nurse lead. There were 30 residents on the days of the audit. Residents and families spoke positively about the care provided. There have been no structural or organisational changes to the facility since the last audit. There was a new electronic medication management system in use.

The unannounced surveillance audit was conducted against a sub-set of the Health and Disability Service Standards and the organisation's contract with the district health board. The audit process included the review of policies and procedures; a sample of resident and staff files; observations, and interviews with residents, management, staff and a general practitioner.

Previous areas requiring improvement relating to worn out floors in the laundry and bathroom, infection control training for the infection control coordinator and document control system were addressed and others relating to documenting outcomes of pro re nata (PRN) medication for effectiveness and having expired PRN medication in stock remain open.

There were six areas identified requiring improvement relating to staff performance appraisals, first aid training, communication of quality improvement data with staff, unwitnessed post fall neurological observations, medication competencies, expired medications.

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.

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. Resident records are maintained as 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

Wensley House's business and quality and risk management plans include the risks (scope, direction, goals, values and mission statement of the organisation). Monitoring of the services by 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, identifying trends and leads to improvement. Staff are involved in quality and risk management, 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 conducted as per policy requirements. A systematic approach to identify and deliver ongoing training supports safe service delivery. Some individual performance reviews were completed. Staffing levels and skill mix meets the changing needs of residents.

Continuum of service delivery

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

The general manager (GM) and clinical nurse lead (CNL) are responsible for the provision of care at each stage of service delivery ,there is adequate information gained through initial assessments , initial care plan and short care plans ,the interRAi assessments and long term care plans based on assessments are completed every six month ,the plans sighted are resident focused ,and set goals guided safe delivery of care, allied health team in put was evident in the sample files reviewed, evaluation of the care plans is done and recorded, the general practitioner (GP) reviews residents every three months and or as required.

The activities team implemented the activities program to meet the individual resident needs, preferences, and abilities. there are regular entertainers, outings, celebrations, and other activities as per program Sighted. Resident /Families interviewed pleased with the activities conducted.

There are medicine management policies and procedures that clearly outline the service provider's responsibilities in relation to all stages of medicine management. There is a newly introduced electronic medication management system in place for all residents. Medications are supplied to the facility in a pre-packaged blister format from a contracted pharmacy. Medication is stored safely in locked cupboards in the nurses' station.

All meals are cooked on site. resident food preferences, likes, dislikes and dietary requirement are identified at the admission and updates as needed. A food control plan was in place.

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.

There have been no changes to the facility and there is a current building warrant of fitness expiring 17 May 2021.

Restraint minimisation and safe practice

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

There are policies and procedures on restraint and enabler use, written information for residents and families on restraint and enabler use sighted. The staff interviewed reported there is no restraint or enabler at the time of audit, and there has been no practice of using restraints or enablers at the facility.

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 surveillance programme is appropriate for the size and complexity of the organisation.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	0	4	0	0
Criteria	0	38	0	0	6	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints management policy and procedures in place that align with the Code. The service's complaint register is detailed regarding dates, timeframes, complaints, and actions taken. All four complaints sighted in the register had been resolved. Complaints information is used to improve services as appropriate. Quality improvements or trends identified are reported to the staff. Residents and family are advised of the complaints process on entry to the service. This includes written information around making complaints. Residents interviewed describe a process of making complaints that includes being able to raise these at the regular residents' meetings, putting a complaint (which can be anonymous) in the suggestion box or directly approaching staff or the general manager.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is an Open Disclosure Policy. Residents and family members interviewed said staff, including management, were easy to talk to, that they kept them well informed and were happy to answer their questions. Family members reported that they are always contacted promptly if there were any issues, even minor ones. Should an interpreter be required one would be sought through the local DHB. There were no residents requiring the use of interpreting services during the time of the audit. The admission agreement and service information are available in large print. Residents sign this agreement on entry to the service. The agreement provides clear information regarding what is paid for by

		the service and by the resident and meets DHB requirements.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	There have been no changes in governance or ownership since the last audit. Wensley House is governed by Experion Care NZ which owns other similar services in New Zealand. The strategic and business plans 2018-2020 was sighted and is reviewed every two years, outlines the purpose, values, scope, direction, and goals of the organisation. The documents describe annual and long-term objectives and the associated operational plans. Six monthly reports to the Director showed adequate information to monitor performance is reported including potential risks, contracts, human resource and staffing, occupancy, maintenance, quality management and financial performance. The general manager (GM) is supported by the clinical nurse lead. The management team meets monthly. All members of the management team are suitably qualified and maintain professional qualifications in management, finance, and clinical skills. The service is managed by the GM who holds relevant qualifications and has been in the role for five years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The service holds contracts with the DHB for rest home and respite services. 28 residents were receiving rest home level care, under the DHB contracts two were under the respite contract.
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.	PA Moderate	The organisation has a planned quality and risk management system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, internal and external audit programme, regular family/resident satisfaction surveys, monitoring of outcomes, clinical incidents and accidents including infections surveillance. Resident and family satisfaction surveys are completed and evidence of this was sighted. Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long Term Care Facility (LTCF) assessment tool 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. These are managed by an external consultant who keeps the service updated on any recent changes. The GM described the process for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The GM is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. The previous area of improvement relating to document control system and having policies and procedures that have details specific to the organisation was addressed.

		An improvement is required to ensure falls data is linked to the quality management system and communicated to staff.
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.	PA Moderate	Staff document adverse and near miss events on an accident/incident form. There is an open disclosure policy in place. Any communication with family and general practitioner (GP) following adverse events and if there is any change in the resident's condition is recorded in residents' records. Family/whanau and the GP interviewed confirmed they are notified in a timely manner. The GM described essential notification reporting requirements, including for pressure injuries, police attending the facility, unexpected deaths, critical incidents, infectious disease outbreaks and missing persons. They advised there have been no notifications of significant events made to the MOH since the previous audit. An improvement relating to completing neurological observations post unwitnessed falls is required.
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.	PA Moderate	Staff files sampled show appropriate employment practices and documentation. Current annual practising certificates are kept on file. Police checks are undertaken. 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 requirements of the providers agreement with the DHB. Two RNs are interRAI trained and competency assessments were sighted in files sampled. The orientation/induction package provides information and skills around working with residents with rest home level care needs. Residents and family interviewed stated that staff are knowledgeable and skilled. Some files reviewed for staff who have been employed for more than 12 months had no current annual performance appraisal and had no first aid training.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	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 implemented and records are maintained. Staffing is increased to meet any increase in the level of care/need. Care staff interviewed reported that there were adequate staff available and that they were able to complete the work allocated to them. In addition to the care staff, there are sufficient numbers of activities staff, cooking, cleaning and maintenance/laundry staff to meet the needs of the residents and ongoing running of the service. Residents and families interviewed reported that there was enough staff to provide them or their relative with adequate

		care. Observations during the audit confirmed adequate staff cover is provided.
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	The medicine management policies and procedures clearly outline the service provider's responsibilities in relation to all stages of medicine management. There is a newly introduced electronic medication management system in place for all residents. the new system has helped to improve the previous medication management paper-based system as reported by the GP and CNL. The fridge temperature monitoring completed; records of weekly check were sighted. The CNL reported staff check the medication room temperature however no records maintained, not sighted during the audit. On the day of the audit, there were no residents self-administering their medicine. There is a medication self-administration policy in place to guide the staff on the process if required. Interviewed staff demonstrated awareness of the medication self-administration process. The previous areas requiring improvement relating to documenting outcomes of PRN medication for effectiveness and having expired PRN medication in stock remains open. An improvement is required to ensure eye-drops in use are dated, weekly and six-monthly controlled drug stock takes are conducted, entries are legible and medication competencies for staff administering medicines are current and there is evidence of medication deliveries, monitoring, returning to pharmacy of expired or unused medications and disposal of medicines.
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	There are two cooks who work on alternative days. The cook responsible oversees the procurement of food and management of the kitchen. The kitchen is adequately equipped. All meals are cooked on site, meals are served at separate dining room areas from hot boxes, the temperature of food is checked before serving. Special equipment such as lipped plates are available. On the day of audit meals were observed to be hot and well presented. Kitchen staff were in the dining area checking with residents regarding meals. There is a kitchen manual and range of policies and procedures to safely manage the kitchen and meal services. Checking of fridge and freezer temperature and kitchen inspection is done and records were sighted. The nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs is available. The CNL reported that residents with malnutrition risk are identified, there is an improvement plan to introduce new tool to the dietary service, the plan included weight monitoring, training for kitchen and care

		staff with consultation from the contracted dietitian. The cook on duty reported feedback is taken from residents on food satisfaction surveys and during meetings with resident and on one-to-one basis. Evidence of resident satisfaction with meals was verified by resident and family interviews, and auditor observation of feedback during residents meeting held on audit day. Any areas of dissatisfaction were promptly responded to. Residents were seen to be given time to eat their meal in an unhurried fashion and those requiring assistance had this provided. There are sufficient staff on duty in the dining rooms at mealtimes to ensure appropriate assistance is available to residents as needed. The kitchen was observed to be clean and tidy, food pending to be served labelled, and food items stored in the fridge with current dates and labels. No expired food items were in stock. The facility had kitchen and food services inspected recently by the national inspection body, inspection report sighted and current certificate in place. The previous area requiring improvement relating to the kitchen registered under the new food control plan and food handling certificates for kitchen staff was addressed.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long term reviewed described the support required to meet the residents' needs, goals, identified allied health professionals' involvement. The interRAI assessment process informs the development of the care plan. Residents, family member/EPOA interviewed confirmed they are involved in the care planning and review process. short term care plans are in use for changes in health status. Staff interviewed reported they found the care plan helpful and guide the residents' care. A previous area requiring improvement relating to care plans reflecting outcomes from interRAI assessment tools was addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When resident condition changes the CNL or GM initiates GP consultation, Staff stated that they notify family representative /EPOA about any changes in in their relative health status. This was confirmed during resident's family /EPOA interviews. Care plan sampled had interventions documented to meet the needs of residents and there is documented evidence of care plans being updated as residents needs change, the updates carried in form of hand written notes added to the original care plan, the changes sighted in the residents' sample files. Care staff interviewed stated there is adequate clinical supplies and equipment provided include continence and wound care supplies.

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 service has qualified Diversional therapist who along with activity assistant manage and run the facility activity program. Between them they cover the 7 days per week providing individual and group activities for rest home residents. An activity assessment is completed on admission. The assessment includes resident likes, dislikes, and preferences. Last hobbies and present interest, residents' files reviewed include comprehensive detailed activity plan based on the assessment. Activities care-plan are reviewed every six months and input integrated in the long-term care plan. There is a weekly program kept in all areas and each resident is given copy of the program to keep in their room. Residents have the choice of variety of activities in which to participate and every effort is made to ensure activities are meaningful and tailored to resident's needs: These include exercises, music played by groups from the community and college, walking groups, bingo, watching movies and others as mentioned in the program. Residents and family members interviewed expressed satisfaction with the activities programme in place. The auditor had a chance to observe one of the activities sessions during audit days.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	A total of six resident files were reviewed. All files had been evaluated by the CNL six monthly and when changes occur. Short term care plans are evaluated and signed off when condition resolves or added to the long-term care plan as an ongoing problem. Activities care plan are in place and current. The multidisciplinary review includes GM, CNL, GP and family/EPOA representative if they wish to attend. In interviews conducted, the family members reported that they are kept informed of any changes identified in the care plan process.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There have been no changes to the facility since the last audit. A current building warrant of fitness was sighted.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout Wensley House Rest Home. This includes rooms with ensuites. Appropriately secured and approved handrails are provided in the toilet and shower areas, and other equipment is available to promote residents' independence. The previous area requiring improvement at the last audit relating to worn out surfaces in the laundry and bathroom walls was addressed.

toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Staff education on infection prevention and control is conducted by the infection control coordinator (ICC) and other specialist consultants. A record of attendance is maintained and was sighted. The infection control training content meets best practice and guidelines. External contact resources included: GP practice, laboratories and local district health boards. There is an understanding of outbreak management where visitors are warned of any outbreak and advised to stay away until contained. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. The previous area requiring improvement relating to ICC attending infection training on current practices was addressed.
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 surveillance programme is appropriate to the size and scope of the organisation. Infection data was collected, and any trends were identified. Interventions were developed to lower infection rates and prevention outcomes were acted upon and evaluated. Information regarding residents' infections was reported at both quality and staff meetings. Updated information on Covid-19 was documented and staff receive regular training.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are policies and procedures on restraint and enabler use, written information for residents and families on restraint and enabler use sighted. The CNL is the restraint coordinator. The restraint coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organization's policies, procedures, practice, and her role and responsibilities. The CNL and staff have been oriented on restraint minimization policy. The staff interviewed reported that there was no restraint or enabler in use at the time of audit, and there has been no practice of using restraints or enablers at the facility.

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 Moderate	Meeting minutes reviewed confirmed regular review and analysis of some quality indicators and that related information is reported and discussed. However, falls statistics were not being identified in health and safety quality meetings and staff meetings. Records reviewed evidence that there was high number of falls occurring in the facility. The GM reports to the director every six months. Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address identified shortfalls.	There was no evidence that falls statistics were discussed or shared with staff.	Ensure that quality improvement is communicated to service providers to meet the requirements of the standard. 90 days
Criterion 1.2.4.3	PA	A sample of incident forms reviewed showed these were fully completed, incidents were investigated, action plans	There was no evidence that neurological observations were	Provide evidence that

The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.	Moderate	developed, and actions followed up in a timely manner. Neurological observations were not being completed when a fall is unwitnessed or where a resident injures their head. Adverse events data is collated, analysed and reported to the management, respectively.	completed for residents following unwitnessed falls.	neurological observations are conducted post unwitnessed falls. 90 days
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Moderate	There is evidence that staff have the required skills and competencies, except for first aid certificates. All staff at Wensley House are required to have a current first aid certificate, including the registered nurses. Most staff's first aid certificates have expired. There was evidence of confirmed bookings of first aid training in November 2020.	Not all staff have a current first aid certificate.	All staff are required to have a current first aid certificate. 90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Moderate	Ongoing education is implemented. Staff education comprises of in-service training onsite, off site seminars and study days to ensure all aspects of service delivery are met. Performance reviews were not being consistently reviewed annually and there was overwriting of dates on staff's previous performance appraisals.	Performance reviews are not conducted annually for all staff.	Complete performance reviews annually for all staff as per policy. 90 days
Criterion 1.3.12.1 A medicines	PA Moderate	Medication is stored safely in locked cupboards in the nurses' station. The controlled drugs (CD) are completed by suitably qualified personnel. Weekly and six-monthly stock	(i)Expired PRN medications were still in use, (ii) not all outcomes of PRN were documented for effectiveness,	Ensure the medication management

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.		taking of CDs by GM or CNL and designated care giver were not regular and consistent. Medicines classified as Class C controlled drug such as codeine and lorazepam were being recorded in the CD register though some entries include illegible writing and cancellations. Updated medication policy to include this was sighted. Medication reconciliation was completed by the CNL. Three monthly medication reviews are completed by the GP in accordance with legislative requirements. Short course medication is signed off by the GP when completed. Medications are supplied to the facility in a pre-packaged blisters format from a new contracted pharmacy. Pro re nata (PRN) medication held in stock were expired and not returned to the pharmacy in a timely manner. There was no documented evidence of medication deliveries, monitoring, returning to pharmacy of expired or unused medications and disposal of medicines. No opening dates on eye-drops in use and not all outcomes of PRN were documented in the electronic medication management system.	(iii) eye drops had no opening dates, (iv) controlled drugs entries were illegible, (v) no evidence of checking and recording of medication room temperature, (vi) weekly and six-monthly control drugs physical stock take was not consistent nor completed in a timely manner,(vii) No evidence of medication deliveries, monitoring, returning to pharmacy of expired or unused medications and disposal of medicines.	system meet the requirements of the standard. 90 days
Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.	PA Moderate	Observed medication administration round was completed by the designated care giver in a correct manner. Additional evidence of safe medication administration processes was observed however some staff administering medication had no current competencies.	Not all staff administering medicines have current medication competencies	Provide evidence that staff administering medicines have current competencies. 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.

No data to display

End of the report.