

# Ropata Lodge Limited - Ropata Lodge

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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:

<b>Legal entity:</b>	Ropata Lodge Limited
<b>Premises audited:</b>	Ropata Lodge
<b>Services audited:</b>	Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 16 September 2021    End date: 16 September 2021
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	32

# 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
	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

Ropata Lodge provides rest home level care for up to 35 residents. The facility is owned by Ropata Lodge Limited and is managed by a facility manager who is a registered nurse. Residents spoke positively about the care provided.

This surveillance audit was undertaken to establish compliance with aspects of the Health and Disability Services Standards and the service's contract with the District Health Board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, a family member, management, staff and a general practitioner.

Areas requiring improvement from this audit relate to residents' care plans and the six-monthly stock take of controlled drugs.

## 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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Effective communication to residents and their family members/friends occurs and interpreter service can be accessed as required.

A complaints register is maintained with complaints resolved promptly and effectively. There has been a complaint investigation by the Health and Disability Commissioner since the previous audit.

## 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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Ropata Lodge Limited is the governing body and is responsible for the service provided. A strategic business plan includes a philosophy, mission, purpose, vision, values and goals. There is regular reporting by the facility manager to the governing body.

The facility is managed by an experienced and suitably qualified manager who is a registered nurse. The facility manager is supported by a registered nurse and the owners of the service.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Quality data is being collated and analysed and showed that corrective action plans are developed and implemented. Staff, resident, quality and management meetings are held on a regular basis. Actual and potential risks, including health and safety risks, are identified and mitigated.

Policies and procedures on human resources management are in place and are followed. An in-service education programme is provided.

There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery that is based on best practice. The facility manager and registered nurse are rostered on call after hours.

## Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to Ropata Lodge is appropriate and efficiently managed with relevant information provided to the potential resident/family.

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

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

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

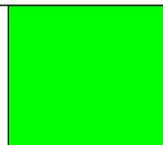


Standards applicable to this service fully attained.

The building warrant of fitness is displayed at the main entrance to the facility. There have been no structural alterations since the previous audit.

## 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.

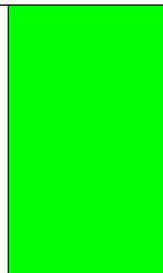


Standards applicable to this service fully attained.

The facility has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. Ropata Lodge practises a no restraint environment. There were no residents using restraints or enablers at the time of audit.

## 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.

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	14	0	1	1	0	0
<b>Criteria</b>	0	37	0	0	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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>	<p>FA</p>	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information is provided to residents and families on admission and there is complaints information available at the main entrance. Residents stated that communication about anything they are concerned about is actioned immediately.</p> <p>Review of the register and interview of the FM evidenced 11 complaints have been received since the last audit. Review of documentation evidenced the complaints were managed well and the timeframes meet Right 10 of the Code.</p> <p>Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There has been a complaint investigation undertaken by the Health and Disability Commissioner (HDC) since the previous audit relating to the care of a resident. Documentation reviewed included a request by the HDC dated 23 January 2020 for information and documents relating to the complaint. A response was sent to the HDC by the FM including copies of the documents requested. A copy of a letter dated 20 June 2021 sent to the HDC from the complainant refers to thanking Ropata Lodge and that they are happy with the changes that have been made as a result of the complaint. A letter from the HDC dated 24 August 2021 to Ropata Lodge suggests an advocate facilitate a meeting between all parties involved. This is yet to be organised.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and a family member interviewed stated they are kept well informed about any changes to their/their relatives health status and outcomes of regular and any urgent medical reviews. The resident/family survey for 2019 and residents' files confirmed this. Staff understood the principles of open disclosure, which is supported by policy and procedures that meet the requirements of the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Interpreter services can be accessed when required. The facility manager (FM) advised residents' family members and staff act as interpreters, where appropriate.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Ropata Lodge Limited is a family business that is responsible for setting the strategic direction and for the service. The strategic business plan 2020-2022 includes a mission, philosophy, purpose, strengths and weaknesses. The service philosophy is in an understandable form, displayed and is available to residents and their family / representative, or other services involved in referring residents to the service.</p> <p>The FM reported they meet with the owners monthly and present a report. Review of the reports confirmed various activities are reported on. The FM also stated they are in contact with the owners on a regular basis either face to face or via a phone conversation.</p> <p>The facility is managed by an experienced FM who is an RN and has been in the position for seven years. The FM is supported by a registered nurse who has at least five years aged care experience. The RN is responsible for oversight of the clinical service with support from the FM.</p> <p>Review of the managers and FM files and interview of the FM and RN evidenced they have undertaken on-going education in relevant areas including attending conferences and forums. They both also facilitate ongoing training for the staff.</p> <p>Ropata Lodge is certified to provide 35 rest home level beds. On the day of audit there were 32 residents - 21 residents under the age-related residential care contract, one resident under the age of 65 years under the chronic health conditions contract and one resident under the respite contract. There are also eight private paying residents (boarders) living in Ropata Lodge. The FM advised Ropata Lodge has always provided this service.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>FA</p>	<p>The quality policy statement and the quality and risk plan are included in the strategic/business plan and guides the quality programme and included quality targets, objectives and risk ratings. Quality data is collected, collated and analysed, including audits, incidents/accidents, surveys and clinical indicators and</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>entered into an electronic programme. Graphs are generated by the programme.</p> <p>Staff, health and safety/quality/infection control and residents' meetings are held regularly. Meeting minutes reviewed confirmed this and evidenced reporting back to staff of corrective actions and trends as a result of analysing quality data. Staff interviewed confirmed this.</p> <p>The resident/relative satisfaction survey for 2019 evidenced a high degree of satisfaction overall. The FM reported a survey was not completed in 2020 due to the Covid-19 pandemic and advised the 2021 survey is now due to be sent out. A staff survey was completed in 2020 that evidenced a high level of satisfaction and this was confirmed during staff interviews.</p> <p>Policies and procedures are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. Policies / procedures are reviewed two yearly and were current. The FM reported updated and reviewed policies are discussed at the staff meetings. Staff confirmed they are advised of updated policies and that the policies and procedures provided appropriate guidance for service delivery. Obsolete policies and procedures are destroyed and a record kept.</p> <p>The risk/hazard register includes risks associated with clinical, human resources, legislative compliance, contractual and environmental risk. Actual and potential hazards are documented, and the actions put in place to minimise or eliminate the hazard. Newly found hazards are communicated to staff and residents as appropriate. The health and safety coordinator is the FM who manages hazards and demonstrated good knowledge. The FM has completed health and safety updates. Staff confirmed they understood and implemented documented hazard identification processes.</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>	<p>FA</p>	<p>Adverse, unplanned or untoward events are documented by staff on incident/accident forms. These are reviewed by the RN who forwards these to the FM who investigates if required. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. The FM is responsible for entering all incident/accidents into the incident/accident analysis register.</p> <p>Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's health status. A family member confirmed they are advised in a timely manner following any adverse event or change in their relative's condition.</p> <p>Policy and procedures comply with essential notification reporting. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files and other documentation confirmed this. The FM reported there have been no section 31 notifications to HealthCERT 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 practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Policies and procedures relating to human resources management are in place. Staff files are managed well and included job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting.</p> <p>New staff are required to complete the orientation programme prior to their commencement of care to residents. The entire orientation process takes at least three days and new staff meet with the FM to review performance and check all subjects have been covered. Orientation for staff covers the essential components of the service provided.</p> <p>The education programme is the responsibility of the FM. In-service education documentation evidenced this is provided in several ways including monthly sessions, some taken by external educators, and some taken by the FM and the RN. Individual certificates of training including competencies are held in the staff files. Both the FM and RN are interRAI trained and have current competencies. Current first aid certificates were sighted in staff files with at least one staff member on each shift with a current first aid certificate.</p> <p>A New Zealand Qualification Authority education programme (Careerforce) is available for staff to complete and they are encouraged to do so. A Careerforce assessor marks their papers. One health care assistant(HCA) has attained level 4, four have attained level 3 and one has attained level 2.</p> <p>The majority of staff performance appraisals were current with two due during the recent Covid-19 lockdown. The FM reported they have these organised to do. Annual practising certificates were current for all staff and contractors who require them to practice.</p> <p>Staff confirmed they have completed an orientation, including competency assessments. Staff also confirmed their attendance at on-going in-service education and the currency of their performance appraisals.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale for determining staffing levels and skill mix to provide safe service delivery. The policy includes the staffing requirement in-line with the contract with the DHB. The FM reported the rosters are reviewed continuously and dependency levels of residents and the physical environment are considered. The FM works full time Monday to Friday. The RN works three days per week and has at least five years' experience in working in aged care. The FM reported they are currently reviewing the RN hours with the view to increasing these to help especially with completing the interRAI assessments. Three HCAs are rostered on the morning shift and two on the afternoon and night shifts. An activities coordinator works Monday to Friday.</p> <p>The FM reported it is currently a 'struggle' to find staff to employ and agency staff are used if needed. The FM and RN are rostered week about on call after hours.</p>

		Care staff reported there are adequate staff available and that they were able to complete the work allocated to them. Residents and a family member reported there were enough staff on duty that provided them or their relative with adequate care. Observations during this audit confirmed adequate staff cover is provided.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Low	<p>The medication management policy is current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system 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 manage.</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 on request.</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 checks and accurate entries. However, the six-monthly physical stocktake has not been completed as required and a corrective action is raised under criterion 1.3.12.1.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>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 review was consistently recorded on the medicine chart. Standing orders are not used.</p> <p>There were no residents who were self-administering medications at the time of audit. The registered nurse described processes in place to ensure this was managed in a safe manner when required.</p> <p>There is an implemented process for reporting and 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</p>	FA	<p>The food service is provided on site by a qualified chef and kitchen team 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, storage, transportation, delivery and disposal</p>

<p>needs are met where this service is a component of service delivery.</p>		<p>comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Hutt City Council. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A 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.</p> <p>Evidence of resident satisfaction with meals was verified by resident interviews, and resident meeting minutes. 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 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation, observations and interviews verified that care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is good.</p> <p>Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the rest home level of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by an activities coordinator five days per week. There is assistance available from a volunteer one to two days per week although this has been limited due to COVID-19 restrictions.</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 as part of the formal six-monthly care plan review.</p> <p>Activities aim to meet the physical, social, intellectual and creative needs of the residents while embracing cultural and spiritual needs. Activities offered reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered including outings. A church service and coffee club occurred on the day of audit and the coordinator described recent activities to celebrate Matariki and a walk to the foreshore on the day prior.</p>

		Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings, and the coordinator is currently analysing a recent survey of residents to inform ongoing programme development. Residents interviewed confirmed they find the programme interesting and varied.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.  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; however, this does not always occur (refer Criteria 1.3.3.3). Examples of short-term care plans being consistently reviewed, and progress evaluated as clinically indicated were noted for infections, and specific medical condition. When necessary, and for unresolved problems, long term care plans are added to and updated,  Residents interviewed provided examples of involvement in evaluation of progress and any resulting changes.
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 is displayed at the main entrance to the facility that expires on the 25 March 2022. There have been no structural alterations since the previous audit.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin and soft tissue, eye, gastro-intestinal, and the upper and lower respiratory tract. The FM, who is a registered nurse, is the IPC coordinator. Standardised infection definitions are used, and all reported infections are documented and reviewed. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.  Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and are displayed in the staff room. Graphs are produced that identify trends for the current year and this is reported to the quality committee. Benchmarking does not occur, but monitoring identifies when infection rates change, and action is taken. The IPC coordinator gave an example of this occurring regarding urinary

		infections which resulted in a reduction in the incidence of infections.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation and safe practice policy includes a definition, assessment and evaluation details and complies with the requirements of the standard. The service has a restraint free philosophy and restraint has never been used. There were no residents using a restraint or an enabler at the time of audit.</p> <p>Staff interviewed demonstrated sound knowledge of the difference between a restraint and an enabler and the process should a resident request an enabler. Staff have received on-going education relating to challenging behaviours, enablers and restraint.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>There are documented policies and procedures to guide safe practice for all aspects of medication management, including prescribing, storage, administration, and disposal. The registered nurse described processes followed and this was verified by observation and review of records.</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 checks. However, six monthly physical stocktakes of controlled drugs have not occurred as required by regulations.</p>	<p>Six monthly physical stocktakes of controlled drugs, including reconciliation of controlled drug register to occur on 30 June and 31 December each year, are not occurring as required by regulations.</p>	<p>Six monthly physical stocktakes of controlled drugs occur as required by regulations.</p> <p>180 days</p>

<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	<p>PA Moderate</p>	<p>The files of six residents including the tracer were reviewed. Files showed that assessment, provision of care and evaluation are occurring within accepted timeframes. Care plans are detailed and described the required support and/or interventions. Residents with specific medical conditions have detailed action plans to guide carers. However, two out of six files reviewed of residents admitted for more than three months did not have a long-term care plan. Both residents had complex medical needs. A further two files did not show any changes to interventions following changes in the resident's condition. For one resident this resulted in the action plan and care plan giving differing information and for the second the care plan did not record the care ordered by the medical practitioner.</p> <p>Short term care planning is in place for short term needs, such as infections.</p>	<p>Not all residents have a long-term care plan completed and/or updated within the time frames required.</p> <ul style="list-style-type: none"> <li>• In two out of six residents' files reviewed, the residents had complex medical needs and no long-term care plan had been completed since admission in May and June respectively.</li> <li>• In two out of six residents' files reviewed the long-term care plan interventions had not been updated following a change in the residents' care needs. For one resident the care plan did not contain sufficient information to guide carers, and for a second resident the information in the care plan conflicted with an action plan in place.</li> </ul>	<p>Long term care plans are developed within 21 days of admission, describe the required support and/or interventions according to the personal goals and information obtained from ongoing assessments, and are updated when a resident's condition changes.</p> <p>90 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.