

Glenbrae Resthome and Hospital Limited - Glenbrae Resthome and Hospital

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 Health and Disability Auditing New Zealand 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:	Glenbrae Resthome and Hospital Limited
Premises audited:	Glenbrae Resthome and Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 15 December 2017 End date: 15 December 2017
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:	42



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

Glenbrae Home and Hospital is owned and operated by the Arvida group. The service provides rest home and hospital – geriatric/medical level care for up to 57 residents. On the day of the audit, there were 42 residents.

This surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The facility manager is a registered nurse and qualified and experienced for the role. The facility manager is supported by a clinical manager (RN) and a clinical nurse leader (RN). The service has an established quality and risk management system. Residents and families interviewed commented positively on the standard of care and services provided at Glenbrae.

Four of the five shortfalls identified as part of the previous certification audit have been addressed. These were around resuscitation directives, the hazard register, interRAI timeframes and care plan documentation. A further improvement continues to be required around medication management.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

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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There is a business plan with goals for the service that has been regularly reviewed. Glenbrae Home has an implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

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 low risk.</p>
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The registered nurses assess, plan and review residents' needs, outcomes and goals with the resident and/or family/whānau input. Care plans viewed in resident records demonstrated service integration and were evaluated at least six monthly. Resident files included medical notes by the general practitioner and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. The registered and enrolled nurses are responsible for administration of medicines and complete annual education and medication competencies.

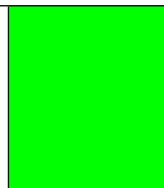
The medicine charts reviewed met legislative prescribing requirements and were reviewed at least three monthly by the general practitioner.

There is an implemented activities programme for the facility that meets the individual recreational, physical, cultural and cognitive abilities and preferences for each resident group. The programme includes community visitors, entertainers and outings.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on-site. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

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.

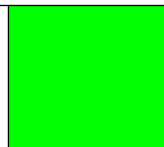


Standards applicable to this service fully attained.

There is a current building warrant of fitness.

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.

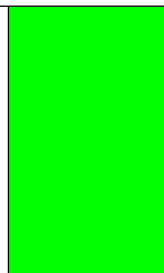


Standards applicable to this service fully attained.

The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were two residents using restraints and no enablers at the time of the 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.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control coordinator (clinical nurse leader) is responsible for the collation of surveillance data. The type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel 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	17	0	1	0	0	0
Criteria	0	43	0	1	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 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Informed consent processes are discussed with residents and families on admission. Written consents are included in the admission agreement. There are signed admission agreements for each resident. The caregivers and the registered nurse interviewed confirmed verbal consent is obtained when delivering care. The service has revised their resuscitation consent process to ensure that the competent resident signs the consent whether they wish to be for or not for resuscitation and where the resident is not competent to make this decision, the medical practitioner considers whether this is clinically indicated or not and documents this accordingly. Five of five resident files reviewed evidenced that resuscitation consents met current legislation. The previous finding related to signing of resuscitation orders has been addressed.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected,</p>	FA	<p>There is a complaints procedure and the complaints process is explained in the service information provided to all residents and families. A record of all complaints, both verbal and written is maintained by the facility manager using a complaints' register.</p> <p>There have been six complaints made in 2017 year-to-date. All complaints have been managed in line with right 10 of the Code. A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered, and all letters include a request for the complainant to comment if they are happy with the resolution. Residents (two rest home and two hospital) and family members advised that they are</p>

and upheld.		aware of the complaints procedure. Family members stated that the service is very responsive to complaints and manages them quickly and well. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. The village manager and clinical nurse manager confirmed family are kept informed. Relatives (three hospital and three rest home) stated that the service is very open and they are notified promptly of any incidents/accidents as well as invitations to multi-disciplinary meetings (six monthly). Residents/relatives have the opportunity to feedback on service delivery through surveys and open-door communication with management. The service has also implemented coffee mornings where relatives can come and have a drink and discuss issues in an informal environment. Staff interviewed stated these are well attended. Monthly resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Relatives interviewed stated they are notified promptly of any changes to residents' health status.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. There is access to an interpreter service as required.</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>	FA	<p>Glenbrae Home and Hospital is owned and operated by the Arvida group. The service provides rest home and hospital – geriatric/medical level care for up to 57 residents. This includes 16 serviced apartments certified to be able to provide rest home level care and 41 dual-purpose beds. On the day of the audit, there were 21 rest home level including one privately funded resident under the care of mental health services and four residents in the serviced apartments. There were 21 hospital level residents. This included one hospital resident receiving care under a younger person disabled contract. All other residents were under the age-related residential care services agreement.</p> <p>The organisation has a vision and mission statement and six core values. The service is also implementing the Wellness model, of resident focused care. The service has a business plan and a quality plan for 2017 – 2018. Achievements against these plans are recorded on an action plan and are reviewed by the senior operations team at least annually. Regular meetings are held between the village manager and head office as well as weekly meetings between the village manager, clinical manager and clinical nurse leader.</p> <p>The facility manager is a registered nurse and maintains an annual practicing certificate. She has been in a management role at the facility for four years. The facility manager is supported by a clinical manager (RN) and a clinical nurse leader (RN). The facility manager has completed in excess of eight hours of professional development in the past twelve months.</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>	<p>FA</p>	<p>Since the previous audit the service has transitioned over to the Arvida Group policies which are reviewed at least every two years across the group. The policies and procedures are implemented and provide assurance that the service is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. Staff (three caregivers, four registered nurses, the chef and the activities person) confirmed they are made aware of any new/reviewed policies.</p> <p>Monthly staff/quality meeting minutes sighted evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. This meeting collates all matters arising from all other smaller meetings to ensure an overall quality approach. The service collates accident/incident and infection control data. Monthly comparisons include trend analysis and graphs which are posted up in the staff room. Additional meetings include monthly RN (where clinical issues are discussed) meetings, bi-monthly night staff meetings, activity and family/resident meetings. The staff interviewed were aware of quality data results, trends and corrective actions.</p> <p>There is a robust internal audit programme that covers all aspects of the service and aligns with the requirements of the Health and Disability Services (Safety) Act 2001. Corrective actions are developed, implemented and signed off.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide practice as well as a separate health and safety meeting. There is a current hazard register which documents review, this is an improvement on the previous audit. Staff confirmed they are kept informed on health and safety matters at meetings.</p> <p>Falls management strategies include assessments after falls and individualised strategies. The service has documented emergency plans covering all types of emergency situations and staff receive ongoing training around this.</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</p>	<p>FA</p>	<p>The service continues to manage the incident and accident process well. There is an accidents and incidents reporting policy. The facility manager investigates accidents and near misses and analysis of incident trends occurs. Incidents and accidents are logged onto a computer software system and a monthly report, including analysis, is presented to monthly staff/quality meetings, health and safety and RN meetings.</p> <p>A registered nurse conducts clinical follow-up of residents. Six resident related incident forms sampled demonstrated that appropriate clinical follow-up and investigation occurred following incidents. Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.</p>

their family/whānau of choice in an open manner.		
<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>	FA	<p>Policies are implemented to support recruitment practices. The register of RNs practising certificates and allied health professionals is current. Six staff files were reviewed (one RN, four caregivers and one enrolled nurse). All files contained relevant employment documentation including current performance appraisals and completed orientations. The service has an orientation programme in place that provides new staff with relevant information for safe work practice in the provision of rest home and hospital level care. There is an annual education planner in place that covers compulsory education requirements. The planner and individual attendance records are updated after each session. All eight RNs have completed interRAI training. Clinical staff complete competencies relevant to their role.</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>	FA	<p>Glenbrae Home and Hospital's policy includes staff rationale and skill mix. The service has adjusted its staffing to accommodate the Wellness model of care that has been recently implemented. The three 'Wellness households' have designated staff and staff work in the same area as much as possible to encourage partnerships with the residents. Sufficient staff are rostered on to manage the care requirements of the residents.</p> <p>In addition to the facility manager (a registered nurse), who works full time, there is a clinical manager (registered nurse) Monday to Friday, a quality manager (RN) two times a week and an interRAI RN once a week.</p> <p>An RN is on duty every shift as well as an enrolled nurse for day shifts. Between the three households there are four caregivers (two long shifts and two short shifts) and an enrolled nurse for the AM shift. For the PM shift there are six caregivers (two long shifts and four shorter shifts over the shift). The night shift has three caregivers, one of whom is based in the serviced apartments.</p> <p>The serviced apartments have a designated caregiver for the AM and PM shift.</p> <p>The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</p>
<p>Standard 1.3.12: Medicine Management</p>	PA Low	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The RN checks all medications (robotic rolls) on delivery against the medication chart and notes this check as</p>

<p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>completed on the medication administration chart supplied by the pharmacy. Any discrepancies are fed back to the supplying pharmacy.</p> <p>Clinical staff who administer medications (RNs and ENs) have been assessed for competency on an annual basis. Registered nurses have completed syringe driver training. All medication is checked on delivery against the medication chart and this was evidenced. All medications are stored safely. Medication fridges are monitored daily and maintained within the acceptable temperature range. All eye drops were dated on opening. Standing orders are not used. There was one resident (rest home) self-medicating their medications on the day of audit. Self-medication competency had been completed and reviewed.</p> <p>Ten of ten medication charts sampled evidenced that prescribed medication for administration daily, weekly, monthly and three monthly were given as prescribed and signed for by the administering RN/EN. Residents requiring oxygen had this prescribed on their medication chart. 'As required' medication is documented on a separate administration record to that of the regular medication administration sheet. These aspects of the previous audit finding have been rectified, however there was evidence in four out of ten medication administration sheets reviewed where medications that required two signatures had not been recorded as per Arvida Policy; there was evidence of transcribing of some medications. The previous finding around medication management remains.</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>All food is prepared and cooked on-site by one of the two cooks and kitchenhands, who between them cover the facility seven days a week. Food services staff have attended food safety training. The six-week seasonal menu has been reviewed by the company dietitian.</p> <p>Cultural preferences and special diets are met. Resident dislikes are known and accommodated. The cook receives a resident dietary profile for new and respite care residents and is notified of any dietary changes. Special diets including modified foods are accommodated. Food is transported in hot boxes and served from bain maries in the units.</p> <p>Fridge and freezer temperatures are taken and recorded twice daily. Cooked food temperatures and serving temperatures are recorded twice daily. Perishable foods sighted in the fridges/chiller were dated. Chemicals are stored safely. The service follows the Food Control Plan guidelines & documentation to evidence management and monitoring of food service. Resident meetings along with direct input from residents, provide resident feedback on the meals and food services generally. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service</p>	<p>FA</p>	<p>Resident care plans reviewed were resident focused and comprehensive. The level of risk as identified in risk assessment tools, the outcome of interRAI assessments and outcomes of assessments following acute changes were documented in the long-term care plans and included appropriate supports/needs to meet the resident</p>

<p>delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>desired goals. Interviews with nursing staff and resident documentation evidenced that the resident or their relative has been involved in the development of the care plan.</p> <p>Resident care plans demonstrate service integration. There was evidence of allied health care professionals involved in the care of the resident including physiotherapist and the referral to the Arvida dietitian.</p> <p>The previous finding around documented supports/needs in care plans has been addressed.</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>When a resident's condition alters, the RN initiates a review and if required, GP, nurse specialist consultation. There is documented evidence in each resident file that evidences family are notified of any changes to their relative's health including (but not limited to) accident/incidents, behaviours, infections, health professional visits, referrals and changes in medications. Discussions with families confirmed they are notified promptly of any changes to their relative's health.</p> <p>Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessment, treatment and evaluation forms were sighted on the electronic resident information system. The frequency of wound reviews is documented at each dressing change and is linked to the work log for that day.</p> <p>There were four facility acquired pressure injures (three stage one and one stage two) for two residents at hospital level of care. An RN has the role of wound nurse and there is access to a wound nurse specialist.</p> <p>Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified.</p> <p>Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission, identifying resident nutritional status and preferences. Monitoring forms are used as applicable and are available on the electronic resident information system.</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,</p>	<p>FA</p>	<p>One diversional therapist and two activities staff are employed part-time to coordinate the five-day activities programme for all residents. Volunteers assist each day and one comes in on a Saturday morning. Each resident has an individual activities assessment on admission and from this information, an individual activities plan is developed. Participation is voluntary and is monitored. There is a high level of community involvement which includes a local early childhood centre which the residents visit fortnightly and take part in activities with the children. New initiatives include 'wonderful Wednesday', an after-dinner club which staff report is well attended.</p> <p>The facility has its own van for weekly outings. All long-term resident files sampled have a recent activity plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents and</p>

and the setting of the service.		families interviewed commented positively on the activity programme.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	All initial care plans for long-term residents were evaluated by the RN within three weeks of admission. Long-term care plans have been evaluated by the RN six monthly or earlier for any health changes, for five permanent resident files reviewed. Written evaluations reviewed identified if the resident goals had been met or unmet. Family are invited to attend the care plan review and informed of any changes if unable to attend. The GP reviews the residents at least three monthly or earlier if required. Ongoing nursing evaluations occur as indicated and are documented within the progress notes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service has a current building warrant of fitness displayed, expiring 24 February 2018.
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	Infection surveillance is an integral part of the infection control programme and is described in the Arvida group infection control manual. Monthly infection data is collected for all infections based on signs, symptoms and definition of infection. The infection control coordinator (clinical nurse lead) is responsible for the surveillance of all infections and entering data into an on-line data base. This data is monitored and analysed for trends monthly and annually. An infection analysis is displayed on the staff noticeboard and discussed at the infection control committee meetings and quality improvement meetings (staff meetings). Benchmarking occurs within the Arvida group. There have been no outbreaks for the facility since March 2016.
Standard 2.1.1: Restraint minimisation Services demonstrate	FA	The service has documented systems in place to ensure the use of restraint is actively minimised. There were two residents with restraint (bedrails) and no residents with an enabler. Both restraint files were sampled. All necessary documentation has been completed in relation to the restraints. Staff interviews, and staff records

that the use of restraint is actively minimised.		evidence guidance has been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0.
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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	There are policies and procedures in place for safe medicine management that meet legislative requirements. Ten of ten medication charts sampled evidenced that medication was given as prescribed and signed for by the administering RN/EN. There were identified gaps on some medication charts.	<p>1) Four out of ten medication charts reviewed had examples of only one signature documented for medications that required two signatures.</p> <p>2) Three resident files reviewed evidenced examples of transcribing of various medications on the non-packaged/PRN signing sheet.</p>	<p>(1)Ensure two signatures are documented for any medication that is identified as requiring two signatories when administered. (2) Ensure that medications noted on non-packaged/PRN signing sheets show only the name of the medication being signed for.</p> <p>30 days</p>

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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.