Radius Residential Care Limited - Radius Lexham Park

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:	Radius Residential Care Limited
Premises audited:	Radius Lexham Park
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 24 January 2019 End date: 24 January 2019

Proposed changes to current services (if any): One room has been verified as suitable for either rest home or hospital level of care.

Total beds occupied across all premises included in the audit on the first day of the audit: 57

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

Radius Lexham is part of the Radius Residential Care Group. The service provides care for up to 63 residents requiring hospital (geriatric and medical) and rest home level care. On the day of the audit there were a total of 57 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 (RN) who is experienced in aged care and has been in the role for over ten years. The manager is supported by a clinical nurse manager who has been in the position for three weeks and an experienced regional manager.

The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The service has addressed two of three findings from the previous audit around staff training and service delivery. Further improvements are required in relation to evaluation of care.

This audit has identified improvements required around interRAI timeframes, and medication administration.

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.

Residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaint processes are implemented, and complaints and concerns are actively managed and well documented.

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.

Services are planned, coordinated and are appropriate to the needs of the residents. A facility manager and clinical nurse manager are responsible for day-to-day operations. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded in practice. Corrective actions are implemented and evaluated where opportunities for improvements are identified.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education and training plan is being implemented that includes in-service education and competency assessments.

Registered nursing cover is provided 24 hours a day, 7 days a week

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.

Care plans are developed by the registered nurses who also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate, they are evaluated at least six-monthly. There is medication management policies and procedures. Each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available and coordinated by the diversional therapist. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

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. Fire evacuations have been undertaken six-monthly.

There are documented processes for the management of waste and hazardous substances in place and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building has a current 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.

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. Staff receive regular education and training on restraint minimisation. There were no residents using a restraint and two residents who had voluntarily requested 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.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

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	13	0	1	2	0	0
Criteria	0	38	0	1	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)
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 policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed could describe the process around reporting complaints. An electronic complaints register includes written and verbal complaints, dates and actions taken. Complaints are being managed in a timely manner, meeting the requirements determined by the Health and Disability Commissioner (HDC). Four complaints were lodged in 2018 and two complaints have been lodged in 2019 (year to date). Evidence of acknowledgement, an investigation and outcomes were documented for the two complaints reviewed. All complaints were documented as resolved. Corrective actions have been implemented and any changes required were made as a result of a lodged complaint (where indicated). The complaints process is linked to the quality and risk management system. Evidence of complaints being discussed in management and staff meetings was sighted in meeting minutes.
Standard 1.1.9: Communication Service providers	FA	Seven residents interviewed (four hospital level including one person on the younger person with a disability (YPD) contract and three rest home level) stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open

communicate effectively with consumers and provide an environment conducive to effective communication.		disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accident reports were reviewed, and all indicated family were informed about the event. Five (hospital level) relatives interviewed confirmed that they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Lexham Park is part of the Radius Residential Care Group. The service can provide care for up to 63 residents requiring hospital and rest home levels of care. There are 50 resident rooms certified as dual-purpose beds. One room in the facility (previously a very large bathroom) has been converted to a resident room. This room was assessed during this surveillance audit as suitable for rest home or hospital level of care. On the day of the audit there were 57 residents. Twenty-eight residents were receiving rest home level care and twenty-nine were receiving hospital level care. Two residents (hospital level) were on a younger person with a disability (YPD) contract (physical disability), one resident (hospital level) was on a palliative care contract, and one resident (hospital level) was on a DHB acute primary care inpatient service contract. The remaining residents were on the aged residential care contract (ARCC). The facility manager is a registered nurse (RN) who has been in the role since 2008. She has over 18 years' experience in aged care management. The regional manager supports the facility manager in the management role. The facility manager is also supported by a clinical nurse manager who was appointed to his role three weeks ago. He is an RN who immigrated from the UK in Dec 2017. He has worked in aged care for six months. This is his first role as a clinical manager. The facility manager has completed more than eight hours of training annually relating to the management of an aged care service. The Lexham Park annual business plan (April 2018 to March 2019) is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Regular reviews are undertaken to report on achievements towards meeting business goals. The manager reports a minimum of monthly to the regional manager on a range of operational matters including (but not limited to) strategic and operational issues, incidents and accidents, complaints and health and safety.
Standard 1.2.3: Quality And Risk Management	FA	An established quality and risk management system is embedded into practice. Quality and risk performance is reported across facility meetings and to the regional manager. Discussions with the facility manager and clinical nurse manager reflected staff involvement in quality and risk management processes. Interviews with eight staff

Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		(two healthcare assistants, one enrolled nurse (EN), one registered nurse (RN), one maintenance, two diversional therapists, one cook) also confirmed this. Resident meetings are bi-monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. The service has policies and procedures, and associated implementation systems to provide an appropriate level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to residents with medical needs and the Health and Disability Services (Safety) Act 2001. Clinical guidelines are in place to assist care staff. The quality-monitoring programme is designed to monitor contractual and standards compliance, and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has established processes to collect, analyse and evaluate data, which is utilised for service improvements. Results are communicated to staff across a variety of meetings and reflected actions being implemented and signed off when completed. Health and safety policies are implemented and monitored by the Health and Safety Committee. The health and safety representative was not available, so the facility manager was interviewed regarding health and safety processes. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Falls prevention strategies are in place including routine visual checks, sensor mats, post falls reviews by a physiotherapist and interventions specific to each individual resident.
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	FA	There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required. A review of ten incident/accident reports that are held electronically identified that each report is fully completed and includes follow up by a RN. Neurological observations are carried out two-hourly for any suspected injury to the head. The facility manager can identify situations that would be reported to statutory authorities with examples provided. This has not been required since the previous audit.

of choice in an open manner.		
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources policies include recruitment, selection, orientation and staff training and development. Six staff files reviewed (one RN, one EN, three healthcare assistants (HCAs), one kitchen manager) reflected evidence of a recruitment process which included reference checking, signed employment contracts and job descriptions, police checks, completed orientation programmes and annual performance appraisals. A register of RN staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice. Staff attend a five-hour orientation programme and are required to complete written core competencies to consolidate information gathered and demonstrate competency. Note: additional training is provided for registered staff. There is an implemented annual education and training plan that is being implemented. All staff participate in education relevant to physical disability and young people with physical disabilities. There is an attendance register for each training session and an individual staff member record of training. Staff complete a competency assessment following attendance at the in-service. Attendance at mandatory training is monitored and linked to the employee's performance appraisal (eg, fire, restraint, Code of Rights, health and safety, cultural training, and infection control). Registered nurses are supported to maintain their professional competency (eg, medication). Two of six RNs have completed their interRAI training. Wound and skin care training was well attended by care staff. Presentations were offered in March and July and were well attended by staff. Wound and skin care training is also covered in other in-services that occur throughout the year (eg, basic cares, continence management, aging process, pressure injury management). In addition to in-service training, staff complete a comprehensive list of annual competencies. This previous finding is now being met by the service.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. There is a full-time facility manager and clinical nurse manager who work Monday to Friday. East wing staffing (27 hospital level and 2 rest home level residents): one staff RN covers the AM, PM and night shifts. A second RN covers two days a week to complete interRAI assessments. This normally occurs over the weekend. Five HCAs cover the AM shift and the PM shift (three long and two short) and one HCA covers the night shift. West wing staffing (14 hospital and 14 rest home): One EN is responsible during the AM shift, and a senior HCA is responsible during the PM shift. They are supported by four HCAs on the AM shift (two long shifts and two short shifts) and three HCAs on the pm shift (one long and two short shifts). One HCA is responsible for the West wing during the night shift. A casual pool of RNs covers absences with agency staff available if needed. An internal pool of part-time HCAs

		covers HCA absences. There are separate cleaning and laundry staff (seven days a week). Two diversional therapists provide cover for activities Monday – Thursday and on the 5th day (Friday) there is one diversional therapist working. Staff working on the days of the audit, were visible and attending to call bells in a timely manner as confirmed by all residents interviewed. Staff interviewed stated that overall the staffing levels are satisfactory and that the managers provide good support. Staffing can be increased if resident acuity is high. Residents and family members interviewed reported there are sufficient staff numbers.
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	Radius Lexham utilises a paper-based medication management system. There are medication policies and procedures that follow recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a fortnightly sachet pack system for tablets and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. Short-life medications (eg, eye drops and ointments) are dated once opened. Education on medication management has occurred with competencies conducted for the registered nurse and senior healthcare assistants with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly. Shortfalls were identified around medication documentation. A registered nurse was observed administering medications and followed correct procedures. There were no expired medications stored.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The service employs an experienced cook and all food is cooked on-site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission and this is provided to the kitchen staff. This document is reviewed at least six-monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the registered nurses on duty. An approved food control plan is in place and verified until November 2019. The kitchen staff have completed food safety training. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.

Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Registered nurses and healthcare assistants follow the care plan and report progress against the care plan each shift at handover. Specialist continence advice is available as needed. A physiotherapist visits the facility for a minimum of six hours weekly. A contracted dietitian is available and provided input when this is required. If external nursing or allied health advice is required, the registered nurse will initiate a referral (eg, to the district nurse, or wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit. Sufficient continence products are available and resident files include a continence assessment. Specialist continence advice is available as needed and this could be described. On the day of audit, there were six skin tears, one surgical wound, two ulcers, six skin lesions and two stage II pressure injuries. All wounds had an assessment, management plan and evaluation documented in the electronic care planning system. Pressure injuries are correctly graded, and the RN interviewed had attended wound management training and was familiar with the stages. All wounds have been reviewed in appropriate timeframes. There was evidence of monitoring charts such as turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management. All charts had been completed as required. Documentation sighted included completed and reviewed fluid monitoring and turning charts and this is an improvement on the previous audit. The previous partial attainment has been addressed.
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 employs two diversional therapists (one full-time and one part-time). Between them they provided activities in the rest home and hospital over five days a week. All recreation/activities assessments and reviews sampled were up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and throughout the facility. Residents had a completed social/activities assessment as part of the computerised assessment process. Individual activities care plans and goals are developed. Activity plans are reviewed six-monthly as part of the six-monthly care plan evaluation process and interRAI review. A record of individual attendance at activities is documented. Activities are age appropriate and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Community linkages are documented. Examples of community involvement include: kindergarten visits; outings to the Katikati men's shed; local agricultural show; Kapa Haka group activities; museum; café; and wearable arts outings. The service provides specific individual activities such as shopping trip and one-on-one crossword activities to meet the needs of younger residents. All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.

Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	PA Moderate	Residents are reassessed using the interRAI process at least six-monthly or if there has been a significant change in their health status. Long-term care plans are then evaluated and updated on the computer software programme. Files reviewed demonstrated that short-term care plans are not always evaluated and resolved or added to the long-term care plan if the problem is ongoing. Where progress is different from expected, or there is an acute change in health needs, the service does not always respond by initiating changes to the care plan. Care plan evaluations are signed as completed by the RN. Short-term care plans were evident for the care and treatment of residents, however, not all had been evaluated. The previous partial attainment continues to require addressing. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes. The registered nurses interviewed explained the communication process with the GP.
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 prominently displayed. Reactive and preventative maintenance occurs. The building has a current building warrant of fitness that expires 21 October 2019. The building has several alcoves and lounge areas. There is a full-time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment is serviced and/or calibrated annually. Essential contractors are available 24 hours. Hot water temperatures are monitored monthly and are maintained between 43-45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. Residents have access to external areas that have seating and shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans. One newly converted room has been verified as suitable for rest home or hospital level of care. The room is large enough to contain mobility equipment (eg, hoist, walking frame) and has a call bell adjacent to the bed and in the shared ensuite. Privacy locks are in place for the shared ensuite.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that	FA	There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Infection reports are completed for all infections including suspected infections that are not treated with antibiotics. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data, trends and analysis is discussed at the monthly clinical and staff/management meetings. Data is sent to head office where the facility is benchmarked against other Radius facilities of similar sizes. Internal audits for infection control are included in the annual audit schedule.

have been specified in the infection control programme.		
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive, and include definitions, processes and use of restraints and enablers. During the audit, there were no residents using a restraint and two hospital level residents using an enabler (one lap belt and one bedrail). One file of a resident using an enabler (bedrail) was selected to review. The enabler assessment is linked to the enabler consent form. Risks associated with this type of enabler are identified as well as the rationale for enabler use. The enabler is reviewed six-monthly by the multidisciplinary team, including the GP, with voluntary written consent provided by the resident (sighted). Annual staff training is in place around restraint minimisation and enablers. Training is linked to a written competency assessment. Completion of training and the written competency is mandatory and is linked to each employee's annual performance appraisal.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.	PA Moderate	The registered nurses in the hospital and senior healthcare assistants in the rest home are responsible for the safe administration of medication. One medication round observed followed correct practice. However, a review of medication charts evidences shortfalls around prescribing practices and signing for administration of medications.	(i)One of ten medication charts had short-term medications with no stop date documented; (ii) Four of ten (two hospital and two rest home) signing charts did not evidence medications were given as charted; (iii) The times of administration of controlled drugs was not entered in the controlled drug register for four entries; (iv) Refusal of regular controlled drugs were documented on an ‘as required’ signing sheet.	(i)Ensure that short-term medications have a stop date documented; (ii) Ensure medications administered are signed for with a signature and according to the medication chart; (iii) Ensure the time of administration of controlled medications are entered in the controlled drug register; iv) Ensure controlled drugs given or refusals are documented on the correct signing sheet. 30 days

Criterion 1.3.3.3 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.	PA Low	All residents have an initial assessment and care plan completed on admission. Initial interRAI assessments have been completed within contractual timeframes for three of the five files reviewed. Two admissions were admitted during a three-month period late last year. Management report that registered nurse turnover has been higher than expected and it has been difficult to arrange timely interRAI training for new RN's.	Two of five files reviewed (both recent admissions) did not have initial interRAI assessments completed within contractual timeframes.	Ensure initial interRAI assessments are completed within 21 days of admission. 90 days
Criterion 1.3.8.3 Where progress is different from expected, the service responds by initiating changes to the service delivery plan.	PA Moderate	Interviews with RN's and HCA's demonstrated that when a resident's needs change this is communicated to all staff at handovers and that all residents are receiving appropriate care for their current needs. However, changes in needs are not always documented in the care plans. Short-term care plans are in place for management of wounds, however, not all had been evaluated in a timely manner. Residents receive analgesia as charted when required for pain relief. Healthcare assistants and RN's interviewed were knowledgeable about pain management, however, effectiveness of 'as required' pain relief was not always documented.	(i)There were no documented interventions for one rest home resident requiring management of leaking oedematous legs as per progress notes. (ii) there were no interventions documented for a resident with recent confusion or for a change in his sleeping position requirements. (iii) A current short-term care plan in place for wound cares had not been evaluated for 30 days. (iv) Effectiveness of 'as required' pain relief was not consistently documented for one rest home and one hospital resident	(i) and (ii) Ensure care plans reflect each resident's current needs. (iii) Ensure short-term care plans are evaluated in a timely manner. (iv) Ensure the effectiveness of 'as required' medication is evaluated. 60 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.