

Kena Kena Rest Home Limited - Kena Kena Rest Home

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:	Kena Kena Rest Homes Limited
Premises audited:	Kena Kena Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 November 2019 End date: 26 November 2019
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:	38

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

General overview of the audit

Kena Kena rest home provides rest home level care for up to 41 residents. On the day of the audit there were 38 residents.

This unannounced 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.

Kena Kena rest home continues to be owned and operated by three directors. Two of the directors are registered nurses. They own another local rest home. The directors are supported by an operations manager, part-time registered nurse and a long-serving workforce. Residents and family interviewed were very complimentary of the service and care they receive at Kena Kena rest home.

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.

One of the two shortfalls identified as part of the previous audit have been addressed. This was around restraint monitoring. There continues to be an improvement required around care plan interventions.

This audit has identified two further areas requiring improvement around medication management and wound care documentation.

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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Kena Kena rest home management and staff provide care in a way that focuses on the individual resident. 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. The quality and risk management plan and quality and risk policies describe Kena Kena rest homes quality improvement processes. 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 medium or high risk and/or unattained and of low risk.</p>
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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 six-monthly or more frequently when clinically indicated. There is a medication management system in place. 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 reported satisfaction with the food service.

Safe and appropriate environment

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The building holds a current warrant of fitness. The preventative and reactive maintenance programme includes equipment and electrical checks. Residents' bedrooms were personalised and of adequate size. Lounges, dining areas and various other small lounges or seating areas are available for residents to sit. External areas are safe and well maintained.

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.
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Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. The restraint coordinator completes consents, assessments and evaluations. Staff receive regular education and training on restraint minimisation. There were two residents with restraint and no enablers in use on the day 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.
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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	15	0	1	2	0	0
Criteria	0	41	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints procedure is provided to residents and relatives at entry to the service. A record of all complaints is maintained by the facility manager using a complaints' register. There have been two complaints for 2019 year to date. Both 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. Four residents and family members interviewed advised that they are aware of the complaint's procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<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 owner/RN manager (RN manager) confirmed family are kept informed. Four relatives stated they are notified promptly of any incidents/accidents. Residents/relatives have the opportunity to feedback on service delivery through annual surveys and open-door communication with management. Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Nine incident forms reviewed evidenced relatives are informed of any incidents/accidents. Four 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</p>

		resident should they wish to do so. There is access to an interpreter service as required.
<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>Kena Kena rest home is certified to provide rest home level care for up to 41 residents. There were 38 permanent residents on the day of audit including one under the long-term chronic health condition contract and a younger person under a residential disability contract. All other residents were under the age-related contract with the DHB.</p> <p>The facility has been owned by three directors for 23 years. The directors also own another rest home facility (Kapiti) which is located nearby.</p> <p>One owner/director is the RN manager for Kena Kena. She is supported by an operations manager responsible for non-clinical services, human resources and accounts/administrative duties. A part-time RN is employed for three days a week at Kena Kena (RN duties and interRAI).</p> <p>There is a business plan that includes the vision, mission and philosophy. There are clinical/nursing objectives and a quality and risk plan. The plans have been personalised to include environmental service upgrades, improved security and staff educational support. The plans document an annual review.</p> <p>The RN manager has attended at least eight hours of professional development relating to her role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The quality and risk management plan and quality and risk policies describe Kena Kena rest home quality improvement processes. Policies and procedures are developed and maintained by an aged care consultant and reviewed regularly to ensure they align with current good practice and meet legislative requirements. Staff are required to read and sign they have read new/reviewed policies.</p> <p>Two-monthly quality assurance meetings evidenced staff discussion around accident/incident data, health and safety, infection control, audit outcomes, concerns and survey feedback. The service collates accident/incident and infection control data. Monthly comparisons include trend analysis and graphs.</p> <p>Facility meetings held include two monthly combined staff meeting with the sister site. This meeting includes operational updates, team building and education (such as stress management).</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. A summary of internal audit outcomes is provided to the quality assurance meetings for discussion. Corrective actions are developed, implemented and signed off.</p> <p>The most recent annual survey documented an overall 94% satisfaction with the service.</p> <p>There is an implemented health and safety and risk management system in place including policies to guide</p>

		<p>practice. The manager is responsible for health and safety education, internal audits and non-clinical accident/incident investigation. There is a current hazard register. 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 detailed 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 their family/whānau of choice in an open manner.</p>	FA	<p>There is an incident reporting policy that includes definitions and outlines responsibilities. Individual reports are completed for each incident/accident with immediate action noted including any follow-up action(s) required. Incident/accident data is linked to the organisation's quality and risk management programme. Nine accident/incident forms were reviewed from October 2019 and evidenced RN assessment and follow-up. Head injury observations are conducted for suspected head injuries. The RN manager and operations manager reported that they are aware of their responsibility to notify relevant authorities in relation to essential notifications. There has been one notification to the around a flood and roof repairs needed. This has since been fully repaired.</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>	FA	<p>There are human resources policies to support recruitment practices. Five files reviewed (one RN, three caregivers, and one cook) included all relevant employment documentation. The recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Three-month appraisals were conducted, then annually thereafter. Performance appraisals were up to date. Current practising certificates were sighted for the nurse manager, part-time RN and allied health professionals.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Long-serving staff interviewed believed new staff were adequately orientated to the service on employment. An annual training programme covering all the relevant requirements is implemented and attendance records are maintained. Monthly training and questionnaires are completed for each training session. Staff are also supported to attend external education as offered. Clinical staff complete competencies relevant to their role including medication competencies.</p>
Standard 1.2.8: Service	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support</p>

<p>Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>across the service.</p> <p>On call is shared by the RN managers from the two sister facilities or the RN from Kena Kena. The owner manager from the sister facility attends handovers at Kena Kena to ensure she is up to date with the resident needs.</p> <p>The RN manager is on duty during the day Monday to Friday and an additional RN three days a week.</p> <p>For the AM shift, there are five short shifts (7 am to 1 pm) and two long shift caregivers. There are two long and two short shifts caregivers (4 pm to 11 pm and 3 pm to 9 pm) for the PM shift as well as a tea assist for three hours. There are two caregivers on nights. There is a designated cleaning person. Care staff complete laundry duties.</p> <p>Residents and relatives stated there were adequate staff on duty at all times. Staff stated they feel supported by the RN and the nurse manager, who respond quickly to after-hour calls.</p>
<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>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. The service uses an electronic medication system. The RNs, and senior caregivers who administer medications complete annual medication competencies. Annual in-service education on medication is provided. Medications (blister packs) are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All medications are stored safely in the locked treatment room. Standing orders are not used. There were no self-medicating residents on the day of audit.</p> <p>Ten electronic medication charts were reviewed. All medication charts had photo identification and an allergy status. The administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The dose and time given is signed for on the administration signing sheet. Staff were observed administering medicines safely.</p> <p>Not all medication processes were according to policy including dating and naming of medications, ensuring medications were in date, the timing of medical reviews and the practice of 're-potting' medications.</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</p>	<p>FA</p>	<p>All food is prepared and cooked on site at Kena Kena Rest Home. There are three cooks that cover the seven-day week. Both cooks have completed food safety units. Tea staff are rostered on duty in the afternoons to cover the evening meal. There is a five-weekly rotating menu that has been reviewed by a dietitian. A food safety plan has been approved and expires November 2020. The meals are served from the kitchen directly to residents in the adjacent dining room. The cook receives notification of any resident dietary changes and requirements. Dislikes and food allergies are known and accommodated. The meals were well-presented, and residents confirmed that they are provided with alternative meals as per request.</p>

service delivery.		Fridge and freezer temperatures were recorded daily. Food temperatures had been taken and recorded daily. A cleaning schedule is maintained. All containers of food stored in the pantry are labelled and dated.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	PA Moderate	<p>An initial plan of care was developed on admission. Residents' long-term care plans reviewed were resident-focused and individualised and developed within three weeks of admission. The audit sample was also extended to include two additional residents with pain management and one resident with warfarin. Not all interventions were included in sufficient detail to guide care staff, this is a continued shortfall from the previous audit.</p> <p>Relatives and residents interviewed, confirmed they were involved in the care planning process. Long-term care plans evidenced resident and/or relative and staff input into the development of care plans. Care plans are reviewed six monthly and updated to reflect changes to supports/needs.</p> <p>The long-term care plan for the younger person and the resident under the long-term chronic health condition contract (who was also under 65 years old) included community links and the resident's preferences.</p> <p>Short-term care plans were sighted for short-term needs and these were either resolved or if an ongoing problem, transferred to the long-term care plan.</p> <p>There was evidence of allied health care professionals involved in the care of the resident.</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>	PA Low	<p>When a resident's condition alters, the RN initiates a review and if required, GP or nurse specialist consultation. There is evidence that family members were notified of any changes to their relative's health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Discussions with families and notifications are documented on the contact with family member record page held within the resident file.</p> <p>Adequate dressing supplies were sighted. Wound management policies and procedures are in place. A wound assessment and wound care plan were in place for identified wounds (two grade two pressure injuries, two chronic ulcers and a two skin tears). Not all wounds had been fully evaluated and wound plans did not all state the nature of the wound.</p> <p>There is access to a wound nurse specialist and district nurses for advice for wound management.</p> <p>Continence products are available. The residents' files included a urinary continence assessment, bowel management plan, and continence products used.</p> <p>Monitoring occurs for blood pressure, weight, vital signs, blood glucose, pain, food intake and challenging behaviours.</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>A diversional therapist is employed Tuesday to Saturday and an activities person Monday to Friday at Kena Kena to coordinate and implement an activity programme.</p> <p>Group activities are provided in the large communal dining room, in seating areas and outdoors in the gardens when weather permits.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on noticeboards.</p> <p>There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary. Younger persons are supported to maintain their community links and are also involved in meaningful activities such as assisting with preparation for theme events. The activity team provides assistance for all residents and also focuses on the needs of younger people in regard to shopping, individualised activities and interests.</p> <p>A resident activity assessment is completed on admission. The recreation assessments included personal interests, family history, work history and hobbies to ensure residents' participation in the activities. Each resident has an individual activity plan, which is reviewed six monthly as part of the multi-disciplinary review. The service receives feedback on activities through one-on-one feedback, monthly activities evaluations, resident's meetings and surveys.</p> <p>During the on-site visit, activities included residents participating in group sessions, listening to music and one-on-one activities. Residents and family confirmed they were happy with the activities programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans reviewed were evaluated by the RNs within three weeks of admission and a long-term care plan developed. Long-term care plans had been evaluated six monthly. Written evaluations identified if the desired goals had been met or unmet. The GP reviews the residents at least three monthly or earlier if required. Short-term care plans reviewed had been evaluated at regular intervals. Daily progress notes were completed by the caregivers with regular input by the RN or manager. Progress notes reflected daily response to interventions and treatments.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided</p>	<p>FA</p>	<p>Maintenance is coordinated by the operations manager. External contractors are used for plumbing, electrical and other specialist areas. There is a maintenance programme in place that ensures buildings, plant and equipment are maintained to an adequate standard. Planned and reactive maintenance systems were in place and documentation to support this was reviewed. Hot water temperatures are monitored monthly and are</p>

<p>with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>		<p>maintained at a safe temperature. There was a current building warrant of fitness displayed that expires 4 June 2020.</p> <p>There is sufficient space for residents to safely mobilise using mobility aids and communal areas are easily accessible. There is safe access to several well-maintained outdoor areas. Seating and shade is provided.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>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 control data is discussed at the monthly quality assurance meeting with representatives from each service area. Meeting minutes are available to staff who read and sign to declare they have read them. The service completes monthly and annual comparisons of infection rates for types of infections. Trends are identified, analysed and preventative measures put in place as required. An outbreak of flu-like symptoms during July 2019 was reported to public health and managed well.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers that meet the restraint minimisation and safe practice standard. The RN manager for Kena Kena is the restraint coordinator. There were no residents with an enabler and two residents with a lap belt restraint (link 1.3.5.2). Staff receive training around restraint minimisation and managing challenging behaviours.</p> <p>Training around restraint minimisation, enablers and challenging behaviour has been provided as part of the orientation for all new staff.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>Procedures around monitoring and observation of restraint use are documented in policy. Approved restraints are documented. The restraint coordinator is responsible for ensuring all restraint documentation is completed. Assessments identify the specific interventions or strategies trialled before implementing restraint. Restraint authorisation is in consultation/partnership with the resident, family and the GP. The internal restraint audit, conducted annually, monitors staff compliance in following restraint procedures. A restraint register is in place providing an auditable record of restraint use and is completed for residents requiring restraints and enablers. One of the two residents with restraint did not have the restraint in the care plan (link 1.3.5.2). Both residents with restraint had monitoring forms which had been completed. This is an improvement from the previous audit.</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 Moderate</p>	<p>The service has policies and procedures to safely provide medication storage and administration. All staff who administer medications had an up-to-date competency. Medications were stored in a secure room.</p>	<p>(i). Eye drops had not been dated on opening for one eyedrop bottle.</p> <p>(ii). Three Ventolin puffers and one epi-pen did not have the resident's name.</p> <p>(iii). One medication was out of date.</p> <p>(iv). Medication reviews were not up to date for three residents.</p> <p>(v). The service has a practice of taking medication out of</p>	<p>(i). Ensure that eye drops are dated on opening.</p> <p>(ii). Ensure that all medications are labelled with the resident's name.</p> <p>(iii). Ensure all medications are within date.</p> <p>(iv). Ensure that medical reviews are documented three monthly.</p> <p>(v). Cease the practice of taking medications out of</p>

			packs and repotting ready for administration. These medications are not labelled in the pots.	their packet prior to the medication round. 30 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	<p>PA Moderate</p>	<p>The registered nurse and RN manager are responsible for completing all necessary assessments and then using this information to document the care plan. Care plans were resident focussed, however not all interventions were documented including pain management, the risks associated with warfarin and restraint.</p>	<p>(i) There was no pain management plan recorded for two residents.</p> <p>(ii) Of the two care plans sampled for residents with restraint, one had no interventions documented.</p> <p>(iii) One resident prescribed warfarin did not have the risks associated with warfarin in the long-term care plan.</p>	<p>(i) Ensure care plans document all interventions for pain management.</p> <p>(ii) Ensure the use of restraint is documented in the resident's care plan.</p> <p>(iii) Ensure the risks associated with warfarin are included in the care plan.</p> <p>60 days</p>
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	<p>PA Low</p>	<p>Six wounds were identified. The registered nurse described the care and intervention for wounds and explained that all wounds were improving. Each wound has an assessment and stated the wound plan and times for redressing/evaluation. Not all wound management plans documented the nature of the wound or had a full evaluation.</p>	<p>(i) Three of six wound management plans did not state the nature of the wound.</p> <p>(ii) Five of six wound management plans did not have a full wound evaluation (size, exudate,</p>	<p>(i)-(ii). Ensure that wound management plans are fully documented including the nature of the wound and full evaluation of the wound as per policy.</p>

			appearance as examples).	90 days
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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.