

Scovan Healthcare Limited - Taurima 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:	Scovan Healthcare Limited
Premises audited:	Taurima Rest home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 20 August 2015 End date: 20 August 2015
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:	25

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

Taurima Rest Home provides rest home level care for up to 28 residents and on the day of the audit, there were 25 residents. The service is managed by a facility manager/registered nurse. The residents and relatives interviewed all spoke positively about the care and support provided.

This unannounced surveillance audit was conducted against a sub-set of the relevant 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 service has addressed one of two shortfalls from the previous certification audit around interventions. Further improvements are required around medication management. This surveillance audit identified that improvements are required in relation to open disclosure, document control, communication of quality management processes, timely long term care plan development, and care planning.

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.		Some standards applicable to this service partially attained and of low risk.
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Families interviewed confirm that they are kept informed. The right of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints that are lodged are followed up in a timely manner.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes an internal audit programme, monitoring adverse events and a health and safety programme that includes hazard management. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An education and training programme for staff is in place. Residents' meetings take place each month.

The service has a documented rationale for determining staffing that meets contractual requirements. Staff, residents and family members report staffing levels are sufficient to meet residents' needs.

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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The registered nurse (RN) is responsible for the resident assessment, development, reviews and evaluations of care plans. The RN has completed InterRAI assessments for all residents. Care plans are developed in consultation with the resident and/or family input. Care plans demonstrate allied health input into the care of the resident. Care plans are evaluated six monthly. The general practitioner reviews the resident at least three monthly or earlier due to health changes.

Medication policies reflect legislative medicine requirements and guidelines. Staff that are responsible for the administration of medicines complete annual education and medicine competencies. An activities programme is in place. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents. Residents expressed satisfaction with the activities provided. All food is prepared on-site. Residents' nutritional needs were identified and documented. Alternative choices are available for dislikes. Meals were well presented.

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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A current building warrant of fitness is posted in a visible location.

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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There are currently no residents requiring enablers. Staff receive training on restraint minimisation and managing challenging behaviours.

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. The infection control coordinator is the registered nurse. The infection control coordinator has attended external training. Staff attend annual infection control education. Surveillance data is collated monthly and analysed to identify quality activities, trends and education needs for the service.

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	12	0	4	1	0	0
Criteria	0	35	0	5	1	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>	<p>FA</p>	<p>The service has a complaints policy that describes how complaints are managed and is in line with requirements set by the Health and Disability Commissioner (HDC). The complaints process is linked to the quality and risk management programme, with evidence of complaints being discussed in manager meetings and staff meetings. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with all six residents and all four family members confirmed that they understand the complaints process. They also confirmed that the facility manager and staff are approachable and readily available if they have a concern.</p> <p>A complaints register is in place. Three complaints lodged in 2015 reflect a timely response for each complaint and evidence that all three complaints have been resolved. The Ministry requested follow up against aspects of a complaint lodged in 2014 through the Health and Disability Commissioner that included management of adverse events, conducting assessments, management of pain and use of controlled drug medication and staff training. The service has made improvements in the areas of incident reporting and management, conducting pain assessments and management of residents' pain (link tracer 1.3.3 and 1.3.6) and staff training around medication management. This audit has identified</p>

		issues with timeliness of care plan development (link 1.3.3.3), care planning for all care requirements (link 1.3.5.2) and aspects of medication documentation (link 1.3.12.1).
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	PA Low	<p>A policy is in place to guide staff on the process around open disclosure. Five of thirteen accident/incident forms reviewed failed to reflect documented evidence of family being kept informed. Interviews with the care staff confirmed family are notified following changes in health status. All four family interviewed stated they were kept informed. Monthly residents' meetings provide a forum for residents to discuss issues or concerns on every aspect of the service.</p> <p>Access to interpreter services is available if needed.</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. The residents and family are informed prior to entry, of the scope of services and any items they have to pay that is not covered by the agreement as confirmed in six resident and four family interviews. The information pack is available in large print and can be read to residents who are visually impaired.</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>Taurima Rest Home provides care for up to 28 residents at rest home level of care. At the time of the audit, there were 25 residents.</p> <p>The service is owned by two individuals who also own an aged care facility in Fielding. A business plan (2014 – 2016) is in place that includes goals, objectives and actions with identified responsibilities and timeframes. Goals are regularly reviewed by the owners and facility manager via regular meetings.</p> <p>The facility is managed by a facility manager who is a registered nurse with a current practising certificate. She is assisted by a full time registered nurse. The facility manager has maintained at least eight hours annually of professional development activities related to managing an aged care facility.</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>	PA Low	<p>Quality and risk management systems are in place. Interviews with all staff (two caregivers, one registered nurse, a cook, and activities coordinator) confirmed their understanding of the quality and risk management programmes.</p> <p>There are policies and procedures being implemented to 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. The content of policy and procedures are detailed to allow effective</p>

		<p>implementation by staff. A policy to control documents is in place but is not being adhered to.</p> <p>The quality and risk management programme includes an internal audit programme and data collection; and analyses and review of adverse events including accidents, incidents, infections, and medication errors. Quarterly management meetings are held with the manager, owners and registered nurse reflecting sound evidence of communication relating to quality and risk. A corrective action process is implemented where opportunities for improvements are identified. Missing is consistent evidence of quality results being communicated to staff in the staff meeting minutes. The health and safety programme includes policies to guide practice. Staff accidents and incidents, and identified hazards are monitored.</p> <p>Falls prevention strategies are in place that includes the analyses of falls and the identification of interventions on a case by case basis to minimise future falls. The service uses hip protectors to reduce injury from falls and sensor mats to reduce the number of falls.</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>Incident/accident forms are completed by staff who either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of the event or if on call, the RN on call is contacted. Thirteen incident/accident forms were reviewed (link 1.1.9.1). Incident/accident forms were completed in a comprehensive manner and reflected follow-up actions taken by the RN. All five residents' files reviewed had the adverse event also documented in the residents' progress notes.</p> <p>Discussions with the facility manager and registered nurse confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.</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. Current practising certificates were sighted for all health professionals. All five staff files randomly selected for review had relevant documentation relating to employment. Annual performance appraisals were completed.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and reported new staff were adequately orientated to the service.</p>

		<p>There is an education plan that is being implemented that covers contractual education topics, and exceeds eight hours annually. The facility manager reports she provides 'real time' staff training, focusing on key issues that arise. Medication training has been provided and care staff who administer medications complete annual competencies.</p> <p>Both RN's have completed InterRAI training. There is a minimum of one care staff with a current first aid certificate on every shift.</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>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery.</p> <p>The facility manager/RN and staff RN work full time, Monday – Friday and share evening, night and weekend call responsibilities. An RN is always available 24/7. Staffing levels meet contractual requirements. Three caregivers (two for the full shift and one for four hours) are assigned on the 'am' shift. Two caregivers are rostered for eight hours each during the evening shift and the night shift. There are separate cleaning staff. Caregiver staff are responsible for laundry duties. One activities staff provides an activities programme for five hours, five days a week.</p> <p>Staff reported that staffing levels and the skill mix were appropriate and safe. Residents and family interviewed advised that they felt there is sufficient staffing.</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>	PA Moderate	<p>The RN and caregivers administer medications. All staff administering medications have completed an annual medication competency and have attended annual medication education with an external pharmaceutical representative in August 2015. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Standing orders are not used. There were no self-medicating residents.</p> <p>There were 10 medication charts sampled. All medication charts sampled showed evidence of being reviewed by the GP three monthly. Two staff check out controlled drugs at the time of administration and sign the administration signing sheet. The previous finding around controlled drugs has been addressed.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid</p>	FA	<p>All food is cooked on site. There is a qualified cook on each day. The menu has been reviewed by the dietitian. The main meal is at midday with a lighter meal for</p>

<p>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>tea including a hot meal option. The cook receives a dietary profile for each resident and is notified of any dietary changes. Residents' dislikes and special dietary requests are known. Diabetic desserts and gluten free meals are provided. Alternatives are offered for resident dislikes.</p> <p>The kitchen is well equipped. The chemical provider conducts monthly service checks on the dishwasher. All perishable foods are dated. The fridges and freezers are temperature monitored weekly. End cooked food temperature is taken and recorded daily. Personal protective equipment is worn as appropriate. A cleaning schedule has been maintained.</p> <p>Residents and family interviewed spoke positively about the meals and home baking. Residents' meetings provide an opportunity for resident feedback on the meals.</p> <p>The food services staff have completed food safety and hygiene training and chemical safety training.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Low</p>	<p>The service use a care plan template that is individualised to meet the residents' needs, however supports were not identified for three out of five residents files sampled. There is documented evidence of resident/family involvement in the care planning process and reviews. There were short-term care plans in place for short-term needs and changes in health status. There is documented evidence of resident/family input into care planning and six monthly reviews. Residents and family confirmed they are involved in the care planning process.</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 health status changes, the registered nurse will review the resident and if required, refer to the GP or nurse specialist for a consultation. There is documented evidence of family notification when a resident's health status changes. Family members stated that staff are approachable if they needed to discuss their relative's health at any time. Residents state their needs are being met.</p> <p>There are adequate dressing supplies available as required. Wound assessment and wound monitoring forms are used to record wound healing. There were two residents with wounds. One chronic wound is linked to the resident's long-term care plan. There was evidence of wound nurse specialist input into wound care.</p> <p>Continence products are available. Resident continence needs are documented in the care plan. The RN could describe the referral process for wound or continence management advice. Pain assessments were in place for residents</p>

		who identified with pain (link tracer #1.3.3). The previous finding around pain assessments has been addressed. Monitoring forms are in use for pain management, weight management and observations.
<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>	FA	<p>The activity officer has been in the role two years. She has a national certificate in the care of the older person and has previously been a caregiver. The activity officer works 25 hours a week Monday to Friday. The weekly programme includes exercises, bowls, and entertainment, visiting pet dog, twice weekly outings and one on one time with residents. The range of activities meets the recreational preferences and individual abilities. Residents interviewed commented positively on the activity programme.</p> <p>Residents are encouraged to maintain community involvement such as the RSA, library bus and shopping. Community visitors include entertainers, Kohanga Reo and monthly church services.</p> <p>The activities officer completes a resident profile and activity lifestyle plan for each resident. The activity plan is reviewed at the same time as the care plan review.</p> <p>Resident meetings provide an opportunity for the residents to provide feedback and suggestions on the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans are evaluated six monthly or earlier due to health changes. Short-term care plans focus on short term issues and are reviewed regularly with ongoing problems transferred to the long-term care plan. Written evaluation forms are used to document progress towards meeting the residents' goals. The six monthly reviews are completed with input from the RN, activities officer and member of the family or resident as appropriate. The GP completes a resident review three monthly.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is posted in a visible location (expiry date 29 September 2015).</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that</p>	FA	<p>Policies and procedures document infection prevention and control surveillance methods. The surveillance data is collected and analysed monthly, to identify areas for improvement or corrective action requirements. Infection control</p>

<p>have been specified in the infection control programme.</p>		<p>internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings (link 1.2.3.6). There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>There are policies around restraints and enablers including definitions. The registered nurse is the restraint coordinator and is knowledgeable regarding this role. During the audit there were no residents using an enabler. Staff receive training around restraint minimisation and managing challenging behaviours.</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 1.1.9.1</p> <p>Consumers have a right to full and frank information and open disclosure from service providers.</p>	PA Low	<p>Incident/accident forms include space for staff to document that family are being kept informed following an adverse event. Evidence of this being documented was missing five of the thirteen incident/accident forms that were randomly selected for review, although all four families interviewed report that they are kept informed of their family's health status, including following an adverse event.</p>	<p>Documentation in five of thirteen incident/accident forms fails to reflect families being informed following an adverse event.</p>	<p>Ensure there is documented evidence of open disclosure with families following an adverse event unless directed otherwise by the resident or family.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document control system to manage the policies and procedures. This system shall ensure documents are approved, up</p>	PA Low	<p>A document control policy is in place that states policies are to be reviewed every two years, with designated policies targeted for review every two months. The current policies and procedures that are in place have not</p>	<p>Policies and procedures have not been reviewed since March 2013.</p>	<p>Ensure policies and procedures are regularly reviewed as per the facility policy on document control.</p>

to date, available to service providers and managed to preclude the use of obsolete documents.		been reviewed since March 2013.		90 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Quality improvement information that is collected includes internal audit results and monthly data from adverse events (eg, resident falls, skin tears, medication errors, bruising). Data that is collected is collated on a month by month basis to identify trends. Missing, is consistent evidence of the results being communicated and discussed with the staff in the meeting minutes.	Staff meeting minutes do not consistently reflect discussions relating to results from quality improvement data.	<p>Ensure quality improvement data is shared with staff in the staff meetings.</p> <p>90 days</p>
<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 Moderate	Medication signing sheets sampled for regular and as required medications charts complied with medication guidelines. The caregiver administering medications was observed to be compliant with medication administration practice. Not all medication charts sampled complied with prescribing requirements.	<p>i) There is no signing sheet or evidence of administration of dietary supplements prescribed for two residents. ii) Two out of ten medication charts did not have a date for each individual medication charted. iii) Five out of ten medications charts did not have indications for use for as required medications (morphine elixir and subcutaneous morphine, salbutamol, furosemide and sevredol). iv) Five out of ten medication charts did not identify the allergy status of the resident.</p>	<p>Ensure medication charts and signing sheets meet legislative requirements as per the medication management guidelines 2011.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of</p>	PA Low	The RN has completed InterRAI assessments for all existing residents and new residents to the service. The outcome of the InterRAI assessment and risk assessment tools are used to develop the long-term care plan. Three of five resident files reviewed evidenced that the long-term care plan was	Two out of five long-term care plans had been developed outside of the three week timeframe.	<p>Ensure long-term care plans are developed within three weeks of admission.</p> <p>90 days</p>

the consumer.		developed within three weeks of admission.		
<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>	PA Low	<p>Two of five care plans reviewed described the residents' needs and care interventions required to support the residents' independence and wellbeing. Care plans are readily available for caregivers. Caregivers interviewed were knowledgeable in individual resident cares.</p>	<p>Three out of five resident care plans sampled did not describe the supports and/or interventions required for one resident's mood and behaviour management, as identified in the InterRAI assessment tool. One resident with a chronic urinary tract infection did not have prevention and management interventions recorded and one resident with deteriorating mental health does not have a recent review and increase in medications recorded.</p>	<p>Ensure individual care plans describe the required supports and/or interventions to achieve resident goals.</p> <p>60 days</p>

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.