# Selwyn Care Limited - Selwyn Sunningdale

## 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Selwyn Care Limited

**Premises audited:** Selwyn Sunningdale Village

**Services audited:** Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 21 March 2016 End date: 21 March 2016

**Proposed changes to current services (if any):** This audit included an assessment of the service to provide hospital services - medical.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 24

# 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** |
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|  | 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 |
|  | 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

Selwyn Sunningdale Village is owned by the Selwyn Foundation Group (SFG) and provides rest home and hospital level care for up to 33 residents. On the day of the audit there were 24 residents. The service is managed by a village manager, assistant village manager and a care lead. The residents and relatives interviewed 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. This audit also included verifying the service as suitable to provide hospital (medical) level of care under their current certification.

The service has addressed the shortfalls from the previous certification audit around documentation of cultural preferences and restraint management. Improvements continue to be required in relation to medication management. This surveillance audit identified that improvements are required in relation to care planning and storage of food.

## Consumer rights

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| 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 families interviewed report that they are kept informed. Residents and their family/whānau are provided with information on the complaints process on admission. Staff are aware of the complaints process and to whom they should direct complaints.

## Organisational management

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| 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 and are appropriate to the needs of the residents. An assistant village manager and care lead/registered nurse are responsible for the day-to-day operations of the facility. They receive support from the village manager. Quality and risk management processes are established. A risk management programme is in place, which includes a risk management plan, incident and accident reporting and health and safety processes.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice and meeting legislative requirements. An orientation programme is in place for new staff. Ongoing education and training for staff is in place. Registered nursing cover is provided 24 hours a day, 7 days a week. There are adequate numbers of staff rostered on to meet the assessed health needs of the residents.

## Continuum of service delivery

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| 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. |

The registered nursing staff is responsible for each stage of service provision. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau to ensure there is safe and appropriate delivery of care.

The residents' needs, outcomes/goals have been identified in the long term nursing care plans and these are reviewed at least six monthly or earlier if there is a change to health status.

The activity programme is developed to promote resident independence, involvement, emotional wellbeing and social interaction appropriate to the level of physical and cognitive abilities of the residents. Spiritual and cultural preferences and needs are being met.

Medication polices reflect legislative requirements and guidelines. Staff responsible for administration of medications completes education and medication competencies.

There is a dietitian review of the menu. All kitchen staff is trained in food safety.

## Safe and appropriate environment

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

The facility has a current building warrant of fitness.

## Restraint minimisation and safe practice

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| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. The service had no residents requiring an enabler.

## Infection prevention and control

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| 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 surveillance programme is appropriate to the size and complexity of the service. Results of surveillance are acted upon, evaluated and reported to relevant personnel.

## Summary of attainment

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

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| **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 | 3 | 1 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 3 | 1 | 0 | 0 |

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| **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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

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| **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 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. Complaints are managed locally with head office oversight. Complaints forms are available at the entrance to the facility. Information about complaints is provided on admission. Interviews with all five residents (three at rest home level of care and two at hospital level of care) and family members confirmed that they understand the complaints process. They also confirmed that the managers and staff are approachable and readily available if they have a concern. Twelve (minor) complaints have been lodged in the past twelve months. The complaints register included all information and correspondence related to each complaint. Timesframes for responding to each complaint were met and all twelve complaints have been resolved. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA |  Residents interviewed 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 disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. The incident/accident forms include a section to record family notification. All seven incident/accident forms reviewed indicated family were informed. Four families interviewed (three rest home level and one hospital level) confirmed they were notified of any changes in their family member’s health status.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Sunningdale is part of Selwyn Care Limited which is wholly owned by the Selwyn Foundation Group (SF Group). The SF Group is governed by a Board of Trustees. There is a 2013 – 2017 organisation wide strategic plan and a 2016-17 Selwyn Sunningdale business plan that contains site specific goals and objectives. The service provides rest home and hospital level care for up to 33 residents. The service is currently certified for hospital services - geriatric and rest home level care. The service has also been verified as part of this audit as suitable to provide medical services under their hospital certification. The service provides Age Related Resident Care (ARRC), palliative care, respite care and post-acute care. On the day of audit, there were 24 residents. There were 22 residents admitted under the ARRC agreement (13 rest home and 9 hospital level care), one rest home respite and one rest home resident on a post-acute care contract. There are four wings. El Alamein has nine beds of which eight are rest home only. The remaining 25 beds in the three other wings (Gallipoli, Cassino and Crete) are dual-purpose. The village manager is a registered nurse (RN). She is supported by an assistant village manager (RN) and a care lead (RN). The village manager reports to the general manager (villages) regularly on a variety of operational issues.The village manager and assistant village manager have completed a minimum of eight hours of professional development relating to the management of an aged care service in the past twelve months.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA |  A 2016 quality and risk management programme is in place. Interviews with all three managers and staff (three caregivers, two registered nurses, one activities assistant one diversional therapist, one cook) reflect their understanding of the quality and risk management systems. Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place and policies are regularly reviewed. Policies and procedures are currently being updated to include reference to interRAI for an aged care service. New policies or changes to policy are communicated to staff, as evidenced in meeting minutes. Data collected (e.g. falls, medication errors, wounds, skin tears, challenging behaviours, pressure injuries) are collated and analysed with results posted in the staffroom. Communication of quality results with staff in staff meetings is evident in the meeting minutes. Corrective actions have been implemented where benchmarked data exceeds targets. An internal audit programme is in place. The organisation has achieved a tertiary level ACC Workplace Safety Management Practice. Health and safety is addressed in the weekly management meetings. Falls prevention strategies include an investigation of residents’ falls on a case-by-case basis to ensure that strategies to reduce falls have been implemented. |
| 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 of choice in an open manner.  | FA | Incident/accident forms are completed by staff that either witnessed an adverse event or were the first to respond. The resident is reviewed by the RN at the time of the event. Seven incident forms were reviewed and all were completed appropriately and in a comprehensive manner. The five residents’ files reviewed demonstrated all documented accident/incident forms for that resident. The events were also documented in the residents’ progress notes. Discussions with the village manager, assistant village manager and care lead confirmed their awareness of the requirement to notify relevant authorities in relation to essential notifications.  |
| 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 | There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses are current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist. Six staff files were reviewed (two caregivers, one registered nurse, one activities assistant, one cleaner and one laundry staff member). Evidence of signed employment contracts, job descriptions, orientation, and training were available for sighting. Annual performance appraisals for staff are conducted for all employees. Newly appointed staff completes an orientation that is specific to their job duties. Interviews with caregivers described the orientation programme that includes a period of supervision. The service has a training policy and schedule for in-service education. The in-service schedule is implemented and attendance is recorded. For those staff members who are unable to attend education, a competency is completed. There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. Sufficient staff is rostered to manage the care requirements of the residents. At least one registered nurse is on-site at any one time. Extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents. |
| 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 | There are policies and procedures in place for safe medicine management that meet legislative requirements. Medication reconciliation is completed on delivery of medications and signed off by the RN checking the medications. Weekly CD register checks have not been consistently carried out. All clinical staff who administers medication have been assessed for competency on an annual basis. Education around safe medication administration has been provided. Staff were observed to be safely administering medications. Registered nurses interviewed were able to describe their role in regard to medicine administration. Standing orders are in use but were not signed by the GP. There were no self-medicating residents on the day of the audit. Ten medication charts sampled (five rest home and five hospital) had indications for use documented for as required medications. This finding from the previous audit has now been addressed. The medication charts sampled identified that the GP had seen and reviewed the resident three monthly.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | PA Low | The main meals at Selwyn Sunningdale are prepared at another Selwyn facility in Hamilton and transported by van in a hot box. Breakfast and supper are prepared on-site by kitchen assistants. A four weekly seasonal menu is designed and reviewed by a registered dietitian. The chef manager (from the other facility) and kitchen assistants receive resident dietary information from the RNs and are notified of any changes to dietary requirements or of any residents with weight loss. The chef manager (interviewed) is aware of resident likes, dislikes and special dietary requirements. Alternative meals are offered for residents with dislikes or religious preferences. Food safety management procedures are not always adhered to, including storage of food. Temperature monitoring of fridges and freezers is carried out daily. Staff were observed wearing correct personal protective clothing in the kitchen. Cleaning schedules are maintained. Staff were observed assisting residents with meals in the dining rooms and modified utensils are available for residents to maintain independence with meals. Food services staff have completed food safety courses. The residents interviewed are satisfied with the variety and choice of meals provided. They are able to offer feedback and menu suggestions at the residents’ meetings and through resident surveys. |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The long-term care plans reviewed describe the support required to meet the resident’s goals and needs and identified allied health involvement.  The interRAI assessment process informs the development of the care plan.  Residents and their family/whānau were involved in the care planning and review process in files sampled.  Short-term care plans were in use for changes in health status.  In one of five files reviewed, the resident identified as Māori.  The care plans documented evidence of a cultural assessment and cultural care plan.  This previous audit finding has now been addressed. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Low | When a resident's condition alters, the registered nurse initiates a review and if required, GP or nurse specialist consultation. The family members confirmed on interview they are notified of any changes to their relative’s health including (but not limited to) accident/incidents, infections, health professional visits and changes in medications. Not all resident files reviewed evidenced that interventions were documented for all identified care needs. Monitoring forms were completed as required and evaluated by a registered nurse. Wound management policies and procedures are in place. Adequate dressing supplies were sighted in treatment rooms. There is evidence of GP, dietitian and specialist involvement in wounds/pressure areas. On the day of audit, the service had one rest home resident with a minor wound. The wound was reviewed by an RN. A wound assessment, management plan, short-term care plan and evaluation were all in place. Continence products are available and residents’ files include a urinary continence assessment, bowel management and continence products identified. Registered nurses were able to describe access to wound and continence specialist input as required.The clinical files sampled evidenced involvement of referral to allied health and specialist services as required, including physiotherapist, dietitian, podiatrist and palliative care team.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | There is one diversional therapist (who was not available for interview on the day of the audit) who provides a programme over five days per week with a volunteer attending on a Saturday providing one on one activities. The diversional therapist has assistance with activity planning from the lead diversional therapist (interviewed) who oversees activities for Selwyn Sunningdale. The diversional therapists attend the Waikato diversional therapy meetings. Activities available include van outings, music therapy, men’s activities, bowls, church services and art and crafts. Joint activities also occur with the other Selwyn homes in Hamilton. The activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. On the day of audit, residents were observed being actively involved in a variety of activities with support and involvement of the staff. The service receives feedback and suggestions for the programme through surveys and at the monthly resident meetings. The residents and families interviewed spoke positively about the activities programme.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | In the resident files reviewed, all initial care plans were evaluated by the RN within three weeks of admission. The written evaluations were completed at least six monthly and described progress against the documented goals and needs identified in the care plan. The GP reviews the resident at least three monthly and more frequently for residents with more complex problems. Ongoing nursing evaluations occur daily and/or as required and are documented in the progress notes.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | There is a current building warrant of fitness which expires on 1 December 2016. |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | 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 internal audits have been completed. Infection rates have been low. Trends are identified and quality initiatives are discussed at staff meetings. 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 since the previous audit. Systems are in place that are appropriate to the size and complexity of the facility. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | There is restraint minimisation and safe practice policies applicable to the service. Guidelines of the use of restraints policy ensures that enablers are voluntary, the least restrictive option and allows residents to maintain their independence. There a restraint and enabler register which accurately documents the enablers and restraints in use. There are currently three hospital residents using restraint and no residents using enablers.  |
| Standard 2.2.2: AssessmentServices shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint. | FA | The service completes comprehensive assessments for residents who require restraint or enabler interventions.  These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the restraint files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process.  In the files reviewed, assessments and consents were fully completed.  There were no enablers in use on the day of audit. However, the restraint coordinator advised that if resident requires an enabler, the GP is involved in the assessment and consent process and is required to sign the enabler consent form. The previous audit findings related to enabler consents have been met. |
| Standard 2.2.3: Safe Restraint UseServices use restraint safely | FA | The Restraint coordinator advised that restraint and enabler usage is documented in the resident’s plan of care and each episode of restraint (or the application of an enabler) is documented on a monitoring form.  The restraint/enabler monitoring form is held in each resident’s room and is completed by caregivers when the restraint or enabler is applied and then removed. A record of all residents using restraints and enablers is held in an electronic restraint register. All residents on the restraint register on the day of audit were using a restraint that complied with the definition of restraint as outlined in the Restraint Minimisation and Safe Practice Standards.  The previous finding related to the restraint register has been met. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.3.12.1A 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 standing orders policies and procedures in place meet legislative requirements, but the standing orders form had not been signed by the GP. Medications were stored safely in line with legislation, however, weekly CD register checks were not consistently carried out. | i) The standing orders form that was in use had not been signed by the GPii) CD register weekly medication checks were not evidenced on eight occasions in the past 12 weeks.  | i) Ensure that standing orders are signed by the GP ii) Ensure that CD register medication checks are completed according to organisational and legislative requirements. 30 days |
| Criterion 1.3.13.5All aspects of food procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines. | PA Low | Food temperatures were monitored and recorded before food was transported to Sunningdale. All staff involved in food preparation have received food safety training. All food stored in the fridge was covered and dated. Dry goods and pantry items were not stored correctly.  | Dry goods are not stored appropriately in the kitchen pantry.  | Ensure that all dry goods and pantry items are stored appropriately. 60 days |
| Criterion 1.3.3.3Each 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 | The registered nurse completes initial assessments and an initial care plan on admission. The long-term care plan is completed within 21 days using the interRAI assessment tool and other relevant clinical assessment tools. Four of five files reviewed had an interRAI assessment completed within the required timeframes. Four of five files sampled had the long-term care plan completed within the required timeframe. |  i) One of five (rest home) admitted in July 2015 did not have an interRAI assessment completed within 21 days of admission; andii) One of five (rest home) did not have the long-term care plan completed within 21 days of admission. |  i) Ensure that all interRAI assessments are completed within the required timeframes.ii) Ensure that all long-term care plans are documented within 21 days of admission.90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Low | Assessments are completed on admission, when the care plan is reviewed and with a change in health condition. The RN reviews information gathered using assessments and monitoring charts to ensure interventions are documented in the care plans to reflect current care needs. Four of five files reviewed evidenced that interventions were documented for all identified care needs.  | The care plan for one hospital resident with unstable diabetes did not document the monitoring and interventions required for the management of hyperglycaemia and hypoglycaemia.  |  Ensure that interventions are documented for all assessed care needs60 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.

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End of the report.