

Deakoda Holdings Limited

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: Deakoda Holdings Limited

Premises audited: Shalom Aged Care

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 1 July 2015 End date: 2 July 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
	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

Shalom Aged Care is certified to provide rest home level care for up to 30 residents. On the day of audit there were 25 residents at the facility.

Shalom Aged Care is privately owned and operated. The administration manager and clinical manager/registered nurse are responsible for the daily operation of the facility. The clinical manager is supported by two registered nurses, one part-time and one casual. Staffing is stable and there are adequate numbers of staff on duty to safely deliver care. A quality programme and risk management system has been implemented with policies in place to guide appropriate quality care for residents. An induction programme and education plan provides staff with appropriate knowledge and skills to deliver care.

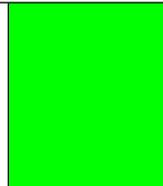
This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. This audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed three of three shortfalls from their previous certification audit around medication management, recording of staff names and designations in resident records and safe storage of chemicals in the laundry.

This audit identified that improvements are required in relation to staff appraisals, care plan interventions and aspects of medication documentation and administration.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.

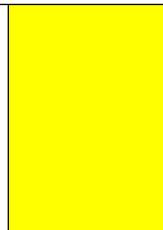


Standards applicable to this service fully attained.

Policies are implemented to support open disclosure in communication with residents and families. Family members are informed in a timely manner when their family members health status changes. There is a complaints register and complaints are documented and managed appropriately.

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.

The 2014 business plan has been reviewed and goals have been developed for 2015. The service policies and procedures are current and reflect best practice. The internal surveys have been collated and communicated to participants. Quality, health and safety and infection control data are discussed at the management and staff meetings. Staff interviewed confirmed they are kept informed on risk management matters. There is an internal audit programme in place. Accidents/incidents are collated monthly and results are available to staff. Services are planned, coordinated, and are appropriate to the needs of the residents. Newly employed staff completed an orientation programme. The education planner covers compulsory training requirements for aged 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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The residents' needs, supports, outcomes/goals have been identified through the assessment process and in consultation with the resident/family/whanau. Care plans are developed within the required timeframe. Care plans are evaluated at least six monthly or earlier as required due to health changes. Resident files include notes by the GP and allied health professionals.

Medication policies and procedures are in place to guide practice. Education and medication competencies were completed by all staff responsible for administration of medicines. The medication charts reviewed include documentation of allergies and intolerances.

The activities programme is facilitated by an activity coordinator. The activities programme provides varied options and activities are enjoyed by the residents. The programme meets the individual recreational needs.

All food is cooked on site. Residents' nutritional needs have been identified and choices accommodated. The menu is reviewed by a dietitian.

Safe and appropriate environment

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

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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No restraints or enablers are being used by the service. Staff receive education and training on 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, is appropriate for the size, complexity, and degree of risk associated with the service. The service has an infection control co-ordinator and infection control committee. Surveillance data is collected monthly and trends and quality improvements identified.

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	2	1	0	0
Criteria	0	37	0	3	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>	FA	<p>The service has a complaints policy that describes the management of the complaints process. Complaints forms are available. Information about complaints is provided on admission. Interviews with four residents and family members confirmed their understanding of the complaints process. They also state that management are approachable and operate an “open door” policy. Staff interviewed were able to describe the process around reporting complaints. The administration manager and manager/RN share the privacy officer role.</p> <p>A complaints register is maintained. One complaint received via the Health and Disability Commissioner (also involving other external services) in December 2013 has been fully investigated and closed off in October 2014. An internal complaint has been managed appropriately within the required timeframes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Nine incident forms reviewed from May 2015 evidence family have been informed of an accident/incident. Interview with one manager/registered nurse, one registered nurse and three caregivers confirm family are notified following changes in health status. Family interviewed (four) stated they were kept well informed.</p> <p>Monthly resident meetings provide a forum for residents to discuss issues or concerns on every aspect of the service. Regular newsletters are sent out to families. Access to interpreter services is available if needed.</p> <p>D12.1 Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised</p>

communication.		<p>resident should they wish to do so. The Ministry of Health “Long-term Residential Care in a Rest Home or Hospital – what you need to know” is provided to residents on entry.</p> <p>D16.1b.ii 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.</p> <p>Residents/family state they receive adequate information on the services on or prior to admission.</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>Shalom Aged Care provides rest home level care for up to 30 residents. On the day of the audit there were 25 residents including one resident for respite care.</p> <p>An annual business plan with goal and objectives is developed in January each year. The 2014 business plan and goals have been reviewed with documented outcomes. There is a 2015 business plan in place that identifies the purpose, values and goals of the business.</p> <p>The facility has been privately owned by the current owner/directors for the last four years. One of the directors is on-site two days a week and is responsible for business finances, actively involved in building maintenance and transporting of residents for appointments. There are two managers employed. The administration manager has been with the service for six years and in the role for 16 months and is responsible for the daily operations of the facility. The manager/RN, who has been in the role 10 years, oversees the clinical management and care team. She is supported by a part-time RN who was appointed a year ago. She had worked for one year post graduation in a medical ward.</p> <p>Six weekly director and management meetings are held that record discussions around daily operations, upgrades, occupancy and marketing.</p> <p>D17.3di both managers have maintained at least eight hours annually of professional development activities related to managing a rest home.</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</p>	FA	<p>A 2015 quality and risk management plan is in place with goals and areas for improvement. A number of quality improvements have been implemented since their last audit including but not limited to: 1) an enquiry/information pack specifically for care staff to issue after hours for any potential enquiries; 2) all care staff have completed formal training; 3) support staff are registered in formal training; 4) the service has participated in district health board projects for reducing falls, polypharmacy review of medications and reduction of psychotropic medications; 5) instillation of Wi-Fi has enhanced resident communication with families/friends; and 6) a volunteer chaplain who has been involved with the service since November 2014 to further meeting residents spiritual needs.</p> <p>Environmental improvements include (but not limited to); new extension of four bedrooms, smaller bedrooms enlarged and all rooms are now single, replacement of bedroom furnishings and furniture as required , painting</p>

improvement principles.		<p>of exterior building, and ongoing replacement of carpets.</p> <p>Policies and procedures are current and reflect best practice. Staff are made aware of any policy changes through regular staff meetings.</p> <p>The monthly collating of quality and risk data includes monitoring accidents and incidents and infection rates. An annual internal audit schedule is in place. Corrective actions are raised for areas for improvement. These have been followed up, signed off and outcomes reported to the management and staff meetings (minutes sighted).</p> <p>Annual resident and relative surveys have been completed in November 2014 and results fed back to the participants and to staff via meetings.</p> <p>Falls prevention strategies are in place that include the identification of interventions on a case-by-case basis to minimise future falls. Medication reviews, physiotherapist assessments, sensor mats and closer supervision are considered and implemented as required.</p> <p>A health and safety programme is in place which includes a hazard identification policy and hazard register. The administration manager is the health and safety coordinator and is supported by a health and safety representative (caregiver). Health and safety is discussed at the management and staff meetings as confirmed on staff interview.</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 including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Incident reports were completed for each incident/accident with immediate action noted and any follow up action required. All seven incident/accident forms reviewed reflected appropriate follow-up actions taken by registered nursing staff.</p> <p>The service collects monthly data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. Staff meeting minutes evidence discussion of incidents and accidents.</p> <p>Discussion with the managers confirmed their awareness of statutory requirements in relation to essential notification.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes</p>	PA Low	<p>Five staff files reviewed contained the required recruitment documentation. There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of the RNs (three) are current. Annual performance appraisals have not been completed for all staff. Newly appointed staff have completed an orientation. Staff complete competencies relevant to their role including medication competencies. The part-time RN has completed InterRAI training and has completed eight of the 25</p>

<p>are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>resident assessments.</p> <p>There is a two yearly education planner that covers the compulsory education requirements. The service has an aged care education programme on-site with access to a contracted assessor. All caregivers hold the national certificate in the support of the older person. The activity person is registered to commence diversional therapy training. The kitchen supervisor is progressing through an external apprenticeship. Cleaning staff have commenced formal training.</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>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is an RN on duty Monday to Friday and available on call after hours.</p> <p>Staff reported that staffing levels and the skill mix is appropriate and safe. Residents and family interviewed advised that they felt there is sufficient staffing. There is a casual pool of staff including a casual RN. The use of agency staff is not required.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents entering the service have the relevant initial information recorded within 24 hours of entry into the service. All five residents' files sighted were sufficiently detailed, dated and timed. InterRAI assessments have the name and designation of the person conducting the assessment and the date and time this was conducted. The previous finding regarding staff including the name and designation of the person making an entry into resident notes (including the RN), has been addressed.</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</p>	<p>PA Moderate</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. RNs and caregivers who administer medications complete competencies, medication questionnaires and medication education on an annual basis. All medications are stored safely. The RN completes a medication reconciliation of all medications on delivery against the medication chart and signs the medication pack and signing sheet. This previous certification finding has been addressed. Two RNs complete an end of page stocktake of controlled medications in the register (sighted). This previous finding has been addressed.</p> <p>There are no standing orders. Self-medication competencies were sighted for self-medicating residents which were reviewed three monthly. The previous finding around three monthly reviews for self-medicating residents has been addressed; however, there was no recorded monitoring of self-administration in place for the</p>

<p>guidelines.</p>		<p>residents.</p> <p>Ten medication charts sampled have photo identification and allergies noted. Signing sheets identified correct administration and documentation on six of ten charts reviewed.</p> <p>D16.5.e.i.2; Ten medication charts reviewed identified that the GP had seen the reviewed the resident 3 monthly and the medication chart was signed. Prescribing of “as required” medications meet prescribing requirements. The service has addressed this previous finding.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a seasonal menu that has been reviewed by the dietitian within the last two years. All baking and meals are prepared and cooked on-site. The kitchen supervisor (interviewed) receives resident dietary profiles that identifies dietary requirements, and likes and dislikes. Alternative choices are accommodated for residents with dislikes. Special diets include diabetic desserts, gluten free and pureed meals. Residents interviewed were complimentary about the meals and baking. Fridge and freezer temperatures are recorded daily. End cooked meat temperatures are recorded daily. Chilled goods (meat) temperatures are recorded on delivery. All foods sighted in the fridge, freezer and pantry were date labelled. Residents have the opportunity to feed back on the food service at the resident meetings. Staff were observed to be wearing appropriate protective clothing.</p> <p>The kitchen supervisor is a qualified cook and is currently progressing on an apprenticeship through an external provider. Safe food handling training has been provided for all staff who work within the kitchen. Staff have attended chemical safety training.</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>PA Low</p>	<p>Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met and they were informed of any changes to health and interventions required. Not all interventions for changes in health had been documented in the files reviewed.</p> <p>Staff report that there are adequate continence supplies and dressing supplies available. There were no chronic wounds or pressure areas. Specialist continence and wound care advice is available as needed.</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</p>	<p>FA</p>	<p>The activities coordinator has been in the role since February 2014. She has previously worked in the disability sector and is registered to commence training towards the diversional therapy qualification. The activities coordinator is employed for 28 hours per week. The activities programme is provided from 9.30am to 2.45pm Monday to Friday. The programme is flexible to meet the needs of residents and to accommodate outings and attendance at community events.</p> <p>The activity programme reflects the resident's recreational preferences such as word games, exercises, bowls,</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>entertainers, newspaper reading and quizzes. Community links are maintained with visiting school children to entertain, inter-home visits and visiting canine pets. They have Catholic church and Anglican church volunteers who visit once monthly, to give communion to those wanting it.</p> <p>Resident meetings are held monthly where feedback on the programme and suggestions for activities and outings are discussed (minutes sighted).</p> <p>A resident social profile is completed in consultation with the resident/family/whanau on admission. Attendance sheets are maintained.</p> <p>Activity plans are reviewed at the same time as the care plans.</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>The initial care plans are evaluated by the RN within three weeks of admission. The RN completes an evaluation on the long term care at least six monthly or earlier due to health changes in consultation with the resident/family and caregivers. Written evaluations monitor and record the resident's progress towards their desired goals. The risk assessments are reviewed six monthly as part of the care plan review. The GP conducts a three monthly resident review.</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>	<p>FA</p>	<p>The building has a current warrant of fitness which expires 1 June 2016.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>There are designated laundry and cleaning staff five days a week. Staff have attended infection control education and chemical safety training. The chemicals are stored safely and securely in the laundry area. This previous audit finding has been addressed.</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>Policies and procedures document infection prevention and control surveillance methods. A senior caregiver with a certificate in adult teaching is the infection control coordinator. The infection control committee meets three monthly where surveillance data is discussed and analysed to determine trends and quality improvement initiatives. Infection control data is collected monthly and collated with information available to staff. Infection control is discussed at management and staff meetings. Relevant authorities were notified and debrief meetings were held following an outbreak in May 2014.</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 including definitions. The registered nurse is the restraint coordinator. During the audit there were no residents using a restraint or an enabler. Staff received training around challenging behaviours July 2014. Staff understand the difference between an enabler and a restraint.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	Education and training needs are discussed at staff meetings. Individual staff attendance records are maintained. Two out of five staff files sampled had annual performance appraisals completed.	Three staff files did not evidence a completed annual performance appraisal (manager/RN, part-time RN and casual RN).	<p>Ensure annual performance appraisals are completed for all staff.</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</p>	PA Moderate	The supplying pharmacy delivers the monthly supply of regular medications and corresponding signing sheets. As required medications are charted by the GP and reviewed three monthly. Standing orders are not used.	<p>1) There is transcribing of controlled drug orders onto the non-packaged signing sheets for the two residents on controlled medication; 2) The administration of Panadol for analgesia, as documented in one resident's progress notes, has not been signed as given on the medication administration signing sheet; 3) Cough mixture administered for one resident has not been prescribed on the medication chart.</p>	<p>1) Cease transcribing orders of controlled medications. 2) Ensure as required medication are signed as administered on the</p>

reconciliation in order to comply with legislation, protocols, and guidelines.				signing sheet. 3) Ensure that only prescribed medications are administered. 30 days
Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.	PA Low	Three self-medicating residents have had a self-medication competency completed by the RN and authorised by the GP. The residents have signed the form acknowledging responsibilities of self-medication. The resident's self-medication status is identified on the medication chart.	There is no evidence of the monitoring of administration of medications for the self-medicating residents	Ensure self-medicating residents are monitored to ensure medications are taken as prescribed. 60 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	When a resident's condition alters, the RN initiates a review and if required, GP referral. Short term care plans were sighted to describe interventions for short term needs such as infections and skin tears. The long term care plans included pain management plans for residents who identified pain.	1) There were no documented interventions for residents with changes to health status as follows: a) post procedure monitoring and management for one resident. The same resident was recently diagnosed with a large hernia for which there were documented interventions/signs and symptoms; b) early warning signs and symptoms for a resident with altered mood/behaviour and recent depressive episode; c) monitoring and management of medical and skin condition for one resident following hospital discharge. 2) There was no monitoring of the effectiveness of as required medication administered for breakthrough pain.	1) Ensure all interventions are documented to reflect the resident's current health status. 2) Ensure as required medications for pain relief are monitored and recorded for effectiveness.

				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.