

Selwyn Care Limited - Sarah Selwyn

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:	Selwyn Care Limited
Premises audited:	Sarah Selwyn
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 31 July 2018 End date: 1 August 2018
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:	75

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

Sarah Selwyn is a Selwyn Foundation aged care facility located in Auckland, situated on the Selwyn Village. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 81 residents. At the time of audit all 75 residents were hospital level.

This unannounced surveillance audit was conducted against a subset of the Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management and staff.

The care manager is an experienced registered nurse and works full time. She has been in the position since November 2017. The care manager is supported by an experienced senior care manager with considerable experience in aged care who has oversight of the four facilities within the Selwyn Village.

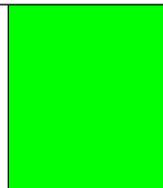
The service has an established quality and risk management system. Residents, families and the general practitioner interviewed commented positively on the standard of care and services provided.

The one shortfall identified as part of the previous audit around medication continues to require.

This audit has identified one further area requiring improvement around documenting care plan interventions.

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.

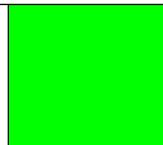


Standards applicable to this service fully attained.

The service has a culture of open disclosure. Families are regularly updated of residents' condition including any acute changes or incidents. Complaints processes are implemented and managed in line with the Code. Residents and family interviewed verified ongoing involvement with the community.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.



Standards applicable to this service fully attained.

There is a business plan with goals for the service that has been regularly reviewed. Sarah Selwyn has a fully implemented, robust, quality and risk system in place. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints and surveys. Incidents are appropriately managed.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation and training programme that provides staff with relevant information for safe work practices. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

Continuum of service delivery

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

Safe and appropriate environment

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

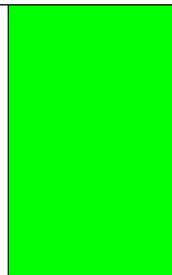


Standards applicable to this service fully attained.

The service has policies and procedures to ensure that restraint is a last resort and safely used when required, and that enabler use is voluntary. There were eight residents using restraints and one with an enabler at the time of the audit.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	15	0	1	1	0	0
Criteria	0	41	0	1	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 complaints process is provided to residents and relatives at entry to the service. A record of all complaints, both verbal and written is maintained by the care manager on the on-line complaints' register. There have been 16 complaints, including two with the Health and Disability Commissioner since December 2017. The two complaints with the Health and Disability Commissioner were both care related and remain in progress. All complaints have been managed in line with Right 10 of the Code.</p> <p>A review of complaints documentation evidenced resolution of the complaint to the satisfaction of the complainant and advocacy offered. Four residents and family members advised that they are aware of the complaints procedure. Discussion around concerns, complaints and compliments was evident in facility meeting minutes.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>There are policies/standard operating procedures in place to guide staff on the process around open disclosure. Staff are required to record family notification when entering an incident into the system. The care manager confirmed family are kept informed.</p> <p>Resident meetings encourage open discussion around the services provided (meeting minutes sighted). Accident/incident forms reviewed evidenced relatives are informed of any incidents/accidents. Four family members interviewed confirmed they are notified following a change of health status of their family</p>

		<p>member.</p> <p>There is an interpreter policy in place and contact details of interpreters were available.</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.</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>Sarah Selwyn is a Selwyn Foundation aged care facility located in Auckland, situated on the Selwyn Village. The facility is certified to provide rest home and hospital (geriatric and medical) level care for up to 81 residents. At the time of audit, all 75 residents were hospital level care including two residents under interim care (non-weight bearing) contracts.</p> <p>The service has a business plan, 2017 – 2018 which is reviewed annually; the plan includes quality plans. The service has quality improvement plans which have been reviewed and updated regularly.</p> <p>The care manager is a registered nurse who has been in the role since November 2017, she has nursing experience from the DHB. The care manager is supported in her role by the senior care manager, also an RN, who has oversight of four facilities within the Selwyn Village. The senior care manager has significant experience within the aged care sector.</p> <p>Both the senior care manager and the care manager have completed at least eight hours of professional development.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Sarah Selwyn continues to implement the established quality and risk management system. Quality and risk performance is reported across facility meetings and to the senior management team. Discussions with the managers (senior care manager, care manager and senior registered nurse), reflected staff involvement in quality and risk management processes.</p> <p>Resident meetings are monthly. Minutes are maintained. Annual resident and relative surveys are completed with results communicated to residents and staff. Survey results have been collated and corrective actions documented, including discussion with family members and residents.</p> <p>The service has standard operating procedures (SOPs) and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The services SOPs are reviewed at a national level by the clinical governance group with input from facility staff every two years. Clinical guidelines are in place to assist care staff. Updates to SOPs included procedures around the implementation of interRAI.</p>

		<p>The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. There are clear guidelines and templates for reporting. The facility has implemented established processes to collect, analyse and evaluate data, which is utilised for service improvements. Key performance areas are benchmarked against other Selwyn facilities. Results are communicated to staff at staff/quality meetings and reflected actions are being implemented and signed off when completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made.</p> <p>Falls prevention strategies are in place including (but not limited to): sensor mats, increased monitoring, identification and meeting of individual needs and mattress perimeter guards.</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>	<p>FA</p>	<p>There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action required.</p> <p>A review of ten incident/accident forms selected through the on-line incident form database for June identified that forms are fully completed and include follow-up by a registered nurse. Neurological observations are completed for any suspected injury to the head. The senior registered nurse and care manager are involved in the adverse event process. There is a debriefing process for all critical incidents that includes a staff debrief and a review of the incident at the clinical governance group.</p> <p>The senior care manager and care manager were able to identify situations that would be reported to statutory authorities including (but not limited to): infectious diseases, serious accidents and unexpected death. There were no section 31 or serious reportable events at the time of audit.</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</p>	<p>FA</p>	<p>There are comprehensive human resources policies in place. Six staff files reviewed (three registered nurses, the activities coordinator and two caregivers) included a comprehensive recruitment process which included reference checking, signed employment contracts and job descriptions, completed orientation programmes and annual performance appraisals. A copy of registered nursing staff and other health practitioner practising certificates is maintained.</p> <p>The orientation programme provides new staff with relevant information for safe work practice. There is</p>

<p>the requirements of legislation.</p>		<p>an implemented annual education and training plan that exceeds eight hours annually. The programme documents that 'tool box talks' are provided where a need has been identified (such as following complaints or an incident) and these have included; the importance of regular resident checks, monitoring the effectiveness of 'as needed' medication, use of short-term care plan, post falls care and manual handling as examples. Compulsory training has included (but not limited to) pressure area prevention, wound management and pain management.</p> <p>Nine of the eleven RNs have completed interRAI training. Clinical staff complete competencies relevant to their role. The RNs and clinical manager have completed syringe driver training and have access to external training. There is an attendance register for each training session and an individual staff member record of training.</p> <p>Registered nurses are supported to maintain their professional competency. There are implemented competencies for registered nurses including (but not limited to): medication competencies, restraint competencies, controlled drug competencies and insulin competencies.</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 human resources policy determines staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.</p> <p>The care manager and senior RN are rostered Monday to Friday and on call. The senior RN takes responsibility for oversight for the interim care residents. There is a trained first aider on each shift. The activity staff also have first aid certificates.</p> <p>The service is on two floors and each floor is staffed separately.</p> <p>Level one (27 of 30 residents on day of audit)</p> <p>AM; two RNs, and six caregivers (three long and three short shifts)</p> <p>PM; one RN and four caregivers (two long and two short shifts)</p> <p>Night; one RN and two caregivers</p> <p>Level two (48 of 50 residents on day of audit)</p> <p>AM; two RNs, and eight caregivers (four long and four short shifts)</p> <p>PM; one RN and six caregivers (three long and three short shifts)</p> <p>Night; one RN and two caregivers</p> <p>Residents and relatives stated there were adequate staff on duty. Staff stated they feel supported by the RN, and care manager who respond quickly to after-hour calls. The GP felt that staffing was adequate</p>

		and noted that staff turnover was high. The management team have implemented orientation and supervision for all new staff. More complex residents (such as the non-weight bearing interim care residents) have a high level of oversight by the senior RN. Regular walk round checks were observed on the day of audit.
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>There are comprehensive policies and procedures (standard operating procedures) in place for all aspects of medication management, including self-administration. The RN checks all medications on delivery against the medication and any pharmacy errors are recorded and fed back to the supplying pharmacy.</p> <p>Registered nurses responsible for the administering of medications have completed annual medication competencies and annual medication education. Caregivers who act as a second checker also had a medication competency. There were no self-medicating rest home residents on the day of audit. The medication room was clean and well organised, all medications were in date and stored appropriately. The medication fridges did not always have temperatures recorded daily.</p> <p>Ten medication charts were reviewed. Photo identification and allergy status were on all charts. Not all medication charts had been reviewed by the GP at least three monthly. There were instances of transcribing and medication administered without a prescription. All medications administered documented a time given. This is an improvement from the previous audit.</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>The residents' individual food, fluids and nutritional needs were met. Residents are provided with a balanced diet which meets their cultural and nutritional requirements. The food service is contracted to an external provider. The meals are cooked on-site in the commercial kitchen that provides for all the facilities on the site.</p> <p>The external contractors have a summer and winter menu reviewed by a registered dietitian as per the contract and they also provide dietetic input into the provision of special menus and diets where required. A dietary assessment is completed on all residents at the time they are admitted. Residents with special dietary needs have these needs identified. Resource information on these diets is available in the kitchen and via the dietitian. Resident forums discuss food and feedback is given.</p> <p>Residents interviewed praised the meals.</p> <p>Special equipment is available such as lipped plates/assist cups/grip and built up spoons and on observing mealtimes it was noted there were sufficient staff to assist residents.</p> <p>The kitchen was observed to be clean and well organised and all aspects of food procurement, production, preparation, storage, delivery and disposal complied with current legislation and guidelines.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	Click here to enter text
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>All five resident files included a resident centred care plan documented through the electronic system. The four-long term resident care plans included an up to date interRAI and care plan. The interim care resident had an initial care plan in place to supplement the DHB care plan. Care plans did not all include all interventions as identified by the interRAI process.</p> <p>Care plans sampled were goal orientated. The staff interviewed stated that they have sufficient equipment and supplies to provide care. Resident weights were noted to be monitored monthly or more frequently if necessary.</p> <p>There were twelve wounds on the wound log at the time of the audit, these included four grade-two pressure injuries and eight minor wounds. Assessments, management plans and documented reviews were in place for all wounds.</p> <p>Specialist nursing advice is available from the DHB as needed.</p> <p>Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed.</p> <p>Residents and family members interviewed confirmed their satisfaction with care delivery.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There are two staff employed (one a diversional therapist and one diversional therapist in training) who are responsible for the planning and delivery of the individual and group activities programme with assistance from staff. There are organised activities for six days per week.</p> <p>Group activities are varied to meet the needs of both higher functioning residents and those that require more assistance. Individual activities are provided in resident's rooms or wherever applicable.</p> <p>On the days of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools. Other activities include the gentlemen's club, bingo, pub quizzes and links to other facilities for joint activities.</p>

		<p>The DT/activities person interviews each newly admitted resident on or soon after admission and takes a social history. This information is then used to develop a diversional therapy plan along with the interRAI (link to 1.3.6.1). The care plan is then reviewed six-monthly as part of the interRAI and care plan review/evaluation process.</p> <p>A record is kept of individual resident's activities and monthly progress notes completed. There is a wide range of activities offered that reflect the resident needs. Participation in all activities is voluntary.</p> <p>Residents interviewed described weekly van outings, musical entertainment and attendance at a variety of community events.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Care plans are evaluated at least six monthly or if there has been a significant change in their health status. There was documented evidence that care plan evaluations were current in resident files sampled. Two residents were new to the service and the interim care resident had not yet required care plan evaluations. Care plan reviews were signed as completed by the RN. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested if issues arise or their health status changes (link 1.3.12.1). The registered nurses interviewed described the communication process with the GP.</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>The building has two levels. The building holds a current warrant of fitness which is displayed. Fire drills occurs six monthly. There is a maintenance work notification book for staff to communicate with maintenance staff on issues and areas that require attention. A preventative maintenance schedule is in place for the service. Hot water temperatures are monitored and recorded monthly. Electrical equipment is tested and tagged. All hoists have been checked and serviced and medical equipment has been calibrated and checked.</p> <p>Residents were observed moving easily around the building with walking aids, wheelchairs and independently.</p> <p>There are outside courtyard areas with seating, tables and shaded areas that are easily accessible. All hazards have been identified in the hazard register.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place, appropriate to the complexity of service provided. The infection control coordinator collects the infection rates each month, identifies trends and uses the information to initiate quality activities within the facility including training needs. Care staff interviewed were aware of infection rates. Systems are in</p>

<p>agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>		<p>place that are appropriate to the size and complexity of the facility. 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>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are comprehensive and include definitions, processes and use of restraints and enablers.</p> <p>There was one resident using an enabler (a lap belt) and eight residents with restraints (seven bedrails and one brief restraint).</p> <p>Staff training is in place around restraint minimisation and enablers, falls prevention and management of 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 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA</p> <p>Moderate</p>	<p>Policies and procedures are in place to guide practice, all staff who administer medications have an up to date medication competency. The medication room was secure, and trolleys supervised always during medication rounds. GP reviews were not all up to date, not all medication was prescribed, care plans documented transcribing of medication and fridge temperature were not consistently monitored.</p>	<p>(i)The medimap self-audit on the day of audit documented that eleven of 74 medication charts were overdue for GP review.</p> <p>(ii) One resident who was receiving oxygen did not have this prescribed.</p> <p>(iii) Two resident care plans transcribed medication to be given (both matched the prescription in the medication chart).</p>	<p>(i)Ensure that medication charted documents a timely GP review.</p> <p>(ii) Ensure all medications are prescribed.</p> <p>(iii) Cease the practice of</p>

			(iv) The medication fridge temperatures were not consistently documented.	transcribing. (iv) Ensure the medication fridge temperatures are documented as monitored as per policy. 30 days
<p>Criterion 1.3.6.1</p> <p>The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.</p>	PA Low	The interim care short-term resident and one permanent resident had a comprehensive care plan in place that reflected the interRAI assessment and the computer based assessments. Three resident care plans did not document interventions to support all assessed needs.	<p>(i) One care plan did include interventions to support resident's mood and activities as identified by the interRAI process. The care plan also did not include interventions or a short-term care plan to identify and support the current wounds on the leg.</p> <p>(ii) One care plan did not include documented interventions for mood as identified by the InterRAI.</p> <p>(iii) One care plan did not include interventions to support the resident's current interests and activities (activity plan).</p>	<p>Ensure that care plans document interventions as identified by the interRAI process.</p> <p>90 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.