

Summerset Care Limited - Summerset Monterey Park

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:	Summerset Care Limited
Premises audited:	Summerset Monterey Park
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: 31 July 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:	21

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

Summerset Monterey Park provides rest home and hospital (geriatric and medical) level care for up to 81 residents. On the day of the audit there were 21 residents in total. Summerset Monterey Park care centre is a new purpose-built facility that opened on 20 March 2018. The village manager is appropriately qualified and experienced and is supported by a care centre manager who oversees the care centre. The residents and relatives interviewed spoke positively about the care and support provided.

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 a review of policies and procedures, the review of resident's and staff files, observations and interviews with residents, family members, staff and management.

The six previous findings identified at the opening partial provisional audit in relation to the completion of the building and implementation of the new service have been addressed.

This audit identified an improvement required around documented 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.
--	--	--

Residents and family are well informed including of changes in residents' health. Management have an open-door policy. Complaints and concerns have been managed and a complaints register is maintained.

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.
---	--	--

The quality and risk management programme has been established since opening and includes a philosophy, goals and a quality planner. The service has commenced implementing quality activities. Meetings are held to discuss quality and risk management processes and to ensure these are further embedded into practice. There is a health and safety management programme available to guide staff. Residents'/family meetings have commenced and are held monthly. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme for 2018 is in place. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

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 low risk.
--	--	---

The registered nurses are responsible for each stage of provision of care. Assessments, resident care plans, and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in resident care. A team of recreational therapists coordinate an integrated activity programme. The activities meet the individual recreational needs and preferences of the resident groups. There are outings into the community and visiting guests/entertainers. There are medicine management policies in place that meets legislative requirements. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly. The food service is contracted to an external company. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

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.
--	--	--

The building has a compliance certificate for public use. The service has an approved fire evacuation plan. Fire evacuation drills occur six monthly. Staff emergency/disaster training has been completed. All external areas were safe and accessible for residents.

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.
---	--	--

Restraint minimisation and safe practice policies are in place to guide staff in the use of an approved enabler and/or restraint. On the day of audit there was one resident with a restraint and two residents using an enabler. Staff training has been provided around restraint minimisation and management of 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.
---	--	--

The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. These included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Somerset facilities. There have been no outbreaks.

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	16	0	1	0	0	0
Criteria	0	41	0	1	0	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The organisational complaints policy states that the village manager has overall responsibility for ensuring all complaints (verbal or written) are fully documented and investigated. A complaints procedure is provided to residents within the information pack at entry. Feedback forms are available for residents/relatives in various places around the facility. There is an electronic complaints' register that includes relevant information regarding the complaint. There has been one complaint received since the care centre opened on 20 March 2018. The reviewed complaint included follow-up with a resolution being completed within the required timeframes.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment	FA	Four residents (two rest home and two hospital) interviewed, confirmed they were given an explanation about the services and procedures. Accident/incidents, complaints procedures and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident. Twelve incidents/accident forms reviewed include a section to record family notification. All forms evidenced family were informed or if family did not wish to be informed. Four relatives (one rest home and three hospital) interviewed, confirmed that they are notified of any changes in their family member's health status. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.

conducive to effective communication.		
<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>Summerset Monterey Park care centre opened on 20 March 2018. The care centre is across two levels with a total of 81 beds. There are 52 dual-purpose beds in the care centre on the first floor and 29 serviced apartments on the ground floor certified to provide rest home level care. On the day of the audit there were 21 residents in total, 11 residents at rest home level and 10 hospital level residents. There were no rest home level residents in the serviced apartments. All residents are under the aged related residential care (ARRC) contract.</p> <p>Summerset group has a well-established organisational structure. Each of the Summerset facilities throughout New Zealand is supported by this structure. The Summerset group has a comprehensive suite of policies and procedures, which will guide staff in the provision of care and services. The Summerset Group Limited Board of Directors have overall financial and governance responsibility and there is a company strategic business plan in place. Summerset Monterey Park has a site-specific 2018 business plan and goals that is developed in consultation with the village manager, care centre manager and regional operations manager. There is a full evaluation completed at the end of the year.</p> <p>The service has a village manager who has been in the role for the last 16 months and was involved in the opening of the village. The village manager has a background in human resources and aged care management. She is supported by an experienced care centre manager (RN) who has been in the role for one year and involved in the aged care industry for nine years. The village manager and care centre manager are supported by a regional operations manager and regional quality manager.</p> <p>The village manager and care centre manager have attended at least eight hours of leadership professional development relevant to the role.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement</p>	FA	<p>Since opening Summerset Monterey Park has established the organisation's quality and risk management system. There are policies and procedures being implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed on a regular basis. The content of policy and procedures are detailed to allow effective implementation by staff. The Summerset group has a 'clinical audit, training and compliance' calendar. The calendar schedules the training and audit requirements for the month and the nurse manager completes a 'best practice' sheet confirming completion of requirements. The best practice sheet reports (but is not limited to): meetings held, induction/orientation, audits, competencies and projects and is forwarded to head office as part of the ongoing monitoring programme. The first annual residents/relatives survey for Monterey Park is not due to be completed until April 2019.</p> <p>There is a meeting schedule including (but not limited to); monthly quality improvement, weekly caregiver and monthly registered staff meetings that include discussion about clinical indicators (e.g., incident trends, infection</p>

principles.		<p>rates). Health and safety, infection control and restraint meetings have occurred monthly. The service is implementing an internal audit programme that includes aspects of clinical care. Issues arising from internal audits are developed into corrective action plans. Monthly and annual analysis of results is completed and provided across the organisation. There are monthly accident/incident benchmarking reports completed by the care centre manager that break down the data collected across the rest home and hospital, and staff incidents/accidents. Infection control is also included as part of benchmarking across the organisation. Health and safety internal audits are completed.</p> <p>Summersets clinical and quality manager analyses data collected via the monthly reports and corrective actions are required based on benchmarking outcomes. There is a health and safety and risk management programme in place including policies to guide practice. The care centre manager is the health and safety representative (interviewed). The service addresses health and safety by recording hazards and near misses, sharing of health and safety information and actively encourage staff input and feedback. Each month there is a health and safety focus topic and staff are provided with resources and education about the topic. The service ensures that all new staff and any contractors are inducted to the health and safety programme. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Incident and accident data is being collected and analysed. A review of 12 incident/accident forms for June and July 2018 identified they were all fully completed, including follow-up by a RN and relative notification. Post falls assessments included neurological observations for six unwitnessed falls with potential head injury reviewed. The incident reporting policy includes definitions and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing. Data is linked to the organisation's benchmarking programme and used for comparative purposes. Discussions with the management team confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been no section 31 notifications completed since the care centre opened in March 2018.</p>
<p>Standard 1.2.7: Human Resource</p>	FA	<p>There are human resources policies to support recruitment practices. Five staff files (one care centre manager, one RN, two caregivers and one recreational therapist/caregiver) were reviewed and all had relevant documentation relating to employment. Performance appraisals are to be completed annually once the care centre has been</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>opened for 12 months. There is sufficient staff employed to cover the staffing roster for safe service delivery. The service provides 24-hour RN cover. The finding at the partial provisional audit around the staffing roster has been addressed. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and believed new staff were orientated well to the service.</p> <p>There is an annual education plan that is outlined on the 'clinical audit, training and compliance calendar'. The 2018 education plan is being implemented. A competency programme is in place with different requirements according to work type (eg, caregivers, RNs and kitchen). Core competencies are completed, and a record of completion is maintained (link 1.3.6.1). Staff interviewed were aware of the requirement to complete competency training and commented that the current education programme was informative and interesting. The service has four of five RNs (including the care centre manager) trained in interRAI. Staff interviewed were aware of the requirement to complete competency 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>	FA	<p>Staffing levels and skills mix policy is the documented rationale for determining staffing levels and skill mixes for safe service delivery. There are clear guidelines for increase in staffing depending on acuity of residents. A staff availability list ensures that staff sickness and vacant shifts are covered. Interviews with residents and relatives confirmed that staffing levels are sufficient to meet the needs of residents. The village manager and care centre manager both work 40 hours per week from Monday to Friday and are available on call for any emergency issues or clinical support. The service provides 24-hour RN cover.</p> <p>In the care centre there were twenty-one residents in total, 11 rest home and 10 hospital residents. There is one RN and three caregivers (two long and one short shifts) on duty in the morning shift, one RN and two caregivers (one long and one short shift) on duty in the afternoon shift and one RN, and one caregiver (long shift) on duty in the night shift. In the serviced apartments there is currently one caregiver on duty in the morning and afternoon shifts, and on the night shift. There were no rest home residents in the serviced apartments at the time of the audit. Five caregivers interviewed confirmed that there is sufficient staff on duty and that staff are replaced.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative</p>	FA	<p>There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice in accordance with the Medicines Care Guide for Residential Aged Care 2011. The RNs are responsible for the administration of medications (including oxygen, insulin and warfarin) and have completed medication competencies. The finding at the partial provisional audit around medication competencies has been addressed. Caregivers complete medication competencies for the checking and witnessing of medications as required.</p> <p>Regular medications are delivered in robotic rolls and were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. There were no self-medicating residents. All medications were</p>

requirements and safe practice guidelines.		stored correctly. All eye drops had been dated on opening. The medication fridge is monitored daily. Ten resident medication charts on the electronic medication system and corresponding medication administration sheets were reviewed. The medication charts had photograph identification and allergy status recorded. Staff recorded the time and date of 'as required' medications. All 'as required' medications had an indication for use. All medication charts had been reviewed by the GP three monthly.
<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>	FA	<p>The service has a contracted company for the provision of all meals on-site. The service has a food safety 'A grade' certificate issued in March 2018 and food control plan issued in February 2018. The 12-weekly menu has been reviewed by a dietitian in May 2018. The menu meets the resident preferences and resident dietary requirements including dislikes. The main meal is in the evening. Meals are delivered in a scan box to the care centre kitchenette where meals are served from the bain marie. The chef and kitchenhand serve the meals. The chef receives a dietary profile for each resident and notified of any changes including weight loss and provides smoothies and added calories such as cream/ice-cream to foods.</p> <p>The fridge, freezer and chiller temperatures are taken and recorded daily. End-cooked food temperatures and serving temperatures are taken and recorded twice daily. All foods are stored correctly, and date labelled. Cleaning schedules are maintained. Staff were observed wearing correct personal protective clothing. The chemical provider completes a functional test on the dishwasher monthly. Staff working in the kitchen have food handling certificates and completed chemical safety training. Residents have the opportunity to feedback on meals through direct feedback and resident meetings. Residents and relatives commented positively on the food services and meals.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	PA Low	<p>When a resident's condition changes, the RN initiates a review and if required a GP or nurse specialist consultation. Relatives interviewed stated their relative's needs are met and they are kept informed of any health changes. There was documented evidence in the resident progress notes of family notification of any changes to health including infections, accidents/incidents, medication changes, GP visits and family meetings. Residents interviewed stated their needs are being met. Not all interventions had been documented to support current needs/supports. Adequate dressing supplies were sighted. Initial wound assessments with ongoing wound evaluations and treatment plans were in place for seven residents with wounds. Two chronic wounds were linked to the long-term care plans. There were no pressure injuries.</p> <p>There is wound nurse specialist advice and support available at the DHB. Adequate pressure injury resources are available and all mattresses on beds are high pressure rating. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Specialist continence advice is available as needed. Monitoring forms are completed on the electronic resident system. Work logs entered onto the system alert staff of monitoring requirements and these are signed off as completed. Registered nurses review the monitoring charts, which include pain monitoring,</p>

		neurological observations, bowel monitoring, two hourly re-positioning, restraint/enablers monitoring and food and fluid intake monitoring.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The service employs three experienced caregivers as recreational therapists (RT) who work in the dual role. The RTs are allocated on the roster for activities from 10.30 am to 3.00 pm Monday to Sunday. The RTs are in the process of registering to commence diversional therapy training. They all have current first aid certificates. The service aims to employ a DT in the future as occupancy increases. The RTs meet with the residents weekly, to plan the next week's activities. The programme is resident driven with care centre activities and integrated activities such as happy hour, movies, coffee groups, genealogy discussions, church services and entertainers in the serviced apartment communal lounge. Staff were observed assisting residents to attend activities of their choice in the care centre and serviced apartments.</p> <p>Activities are flexible and weather dependent and include baking, gardening, arts and crafts, card groups, word games, walks and exercises including weekly physiotherapy exercises. For residents who choose not to join in activities there are pampering sessions and one-on-one time with the RTs. There are regular outings and drives. There are volunteers and community visitors involved in the activity programme including weekly primary school children visits, high school students and students on work placements. There is a recreational assessment and activity plan in place for all files reviewed. The residents and relatives interviewed expressed satisfaction with the programme, which redirected their preferences.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>All initial care plans were evaluated by the RNs within three weeks of admission. There is evidence of resident and family involvement in the evaluation of the initial care plan. Written evaluations for long-term residents had not yet been completed as residents had not been at the service six months. Evaluation tools against resident goals were sighted on the electronic resident system and require resident/relative involvement in the care plan evaluation. The GP completes three monthly reviews.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and</p>	FA	<p>Summerset Monterey Park care centre opened on 20 March 2018. The building is two levels with the care centre on the first floor and the serviced apartments on the ground floor. The building has a certificate for public use that expires 5 September 2018. Lift and stair access has been completed and all external areas were safe and accessible for residents (sighted at the time of the audit). The findings at the partial provisional audit around the building code of compliance and safe external areas have been addressed.</p>

facilities that are fit for their purpose.		
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Summerset Monterey Park has an approved fire evacuation plan dated 23 January 2018. Fire evacuation drills occur six monthly with the last drill occurring on 14 May 2018. Emergency/disaster training was completed on 11 May 2018 with 20 staff attending. The findings at the partial provisional audit around an approved fire evacuation plan, fire evacuation drill and emergency/disaster training have 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>	FA	<p>The infection control policy includes a surveillance policy including a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered into the electronic system. The infection control coordinator (care centre manager) provides infection control data, trends and relevant information to the combined quality/infection control/health and safety meeting. The monthly infection events, trends and analysis are reviewed by management, and data is forwarded to head office for benchmarking. Areas for improvement are identified corrective actions developed and followed-up. Infection control audits are completed, and corrective actions signed off. Surveillance results are used to identify infection control activities and education needs within the facility. There have been no outbreaks.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. Interviews with the caregiver and nursing staff confirmed their understanding of restraints and enablers. The service currently has one resident assessed as requiring the use of restraint (bed rails) and two requiring enablers (bed rails). Residents voluntarily request and consent to enabler use. The two resident files using enablers were reviewed and included an assessment and consent for use of an enabler. Staff training has been provided around restraint minimisation 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)
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	Changes to health and short-term interventions are updated on the long-term care plans, however not all interventions had been documented to meet the short-term needs/supports for three hospital level residents.	i) There was no pain management plan in place for one hospital resident who identified with pain, ii) there were no documented interventions for a hospital resident with unintentional weight loss and dietary requirements and iii) there were no documented signs, symptoms, treatment and management for one hospital resident with insulin dependent diabetes.	Ensure there are documented interventions in place for identified clinical risk. 60 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, 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.