# St Johns Hill Healthcare 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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** St Johns Hill Healthcare Limited

**Premises audited:** St Johns Hill Healthcare

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

**Dates of audit:** Start date: 7 April 2016 End date: 7 April 2016

**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:** 54

# 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 |
|  | 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

St John’s Hill Healthcare is a privately owned facility in Whanganui. The facility can provide a range of aged residential care services under contract to the Whanganui District Health Board including rest home, hospital (both medical and geriatric), intermediate care and palliative care services to the Taranaki District Health Board.

Up to 56 residents can be accommodated and all beds are reported to be dual purpose. 54 beds were occupied on the day of this unannounced surveillance audit with 30 residents at rest home level and 24 at hospital level, which included one person under the intermediate care contract.

This audit has identified that improvements are required in relation to ensuring that all interRAI assessments are kept up to date and that documentation in relation to the self-administration of some medications is completed and current.

## Consumer rights

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

Communication with residents and family members is open and records are maintained to record this. When needed, information about adverse events and complaints is reported formally and respectfully. Complaint forms are accessible in the facility. The complaints register is current and complaints reviewed demonstrate a respectful process is followed to respond to all issues raised.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Standards applicable to this service fully attained. |

The organisation has a current governance statement and quality plan. The documents include the organisation’s values, scope, direction and purpose. The facility manager and clinical nurse leader have appropriate skills, knowledge and experience to undertake their roles.

The quality and risk management system includes document management and control, collation and analysis of quality improvement data, review of progress against the quality objectives, identification and monitoring of risks on the risk register and corrective action planning. All adverse events are reported and recorded and staff members are involved in the response to and management of events. Trends are identified and managed.

The facility’s human resources are managed guided by a suite of policies and procedures which reflect good employment practices. Professional staff have their practising certificates monitored along with contracted health and allied health professionals. Recruitment of new staff follows the organisation’s documented systems. Staffing levels meet the requirements of the provider’s contracts with two district health boards, the needs of residents and reflect the indicators for safe aged care staffing allocations which are used to guide the rostering process.

## Continuum of service delivery

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| Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation. |  | Some standards applicable to this service partially attained and of low risk. |

Residents’ needs are assessed on admission by the multidisciplinary team, however not all files reviewed provided evidence that needs, goals and outcomes are identified and reviewed within required timeframes. A previous corrective action requiring evaluation as to the effectiveness of interventions, in achieving desired outcomes, has been addressed. Residents and families interviewed reported being well informed and involved and that the care provided is of a high standard.

An activities programme exists that includes a wide range of activities and involvement with the wider community.

Well defined medicine policies and procedures guide practice. Practices sighted were consistent with these documents; however an improvement is required around facilitating the residents’ safe self administration of inhalers. A previous requirement around medicine reconciliation has been attended to.

The menu has been reviewed by a registered dietician as meeting nutritional guidelines, with any special dietary requirements and need for feeding assistance or modified equipment met. Residents and family members have a role in menu choice and interviews with residents and family members verified satisfaction with meals.

## Safe and appropriate environment

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

There is a current building warrant of fitness which expires in June 2016. The environment is maintained to a high standard and is appropriate for the population. Internal and external areas are safe and appropriate for residents to access and use independently or with mobility equipment / assistance.

## Restraint minimisation and safe practice

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

One resident was using an enabler on the day of the audit visit. The use is voluntary and records reviewed confirmed that they are supported to use the equipment safely and it promotes their wellbeing.

## Infection prevention and control

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

Surveillance of infections was occurring according to the descriptions of the process in the programme. Data on the nature and frequency of identified infections has been collated and analysed. Surveillance results are benchmarked internally. The results of surveillance are reported through all levels of the organisation, including governance.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 14 | 0 | 2 | 0 | 0 | 0 |
| **Criteria** | 0 | 38 | 0 | 2 | 0 | 0 | 0 |

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| **Attainment Rating** | **Unattained Negligible Risk**  **(UA Negligible)** | **Unattained Low Risk**  **(UA Low)** | **Unattained Moderate Risk**  **(UA Moderate)** | **Unattained High Risk**  **(UA High)** | **Unattained Critical Risk**  **(UA Critical)** |
| **Standards** | 0 | 0 | 0 | 0 | 0 |
| **Criteria** | 0 | 0 | 0 | 0 | 0 |

# Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | The complaints process is accessible within the facility, to both residents and family members. It is compliant with Right 10 of the Code of Health and Disability Services Consumers Rights. Review of the complaints made over the past 18 months indicated that residents and family members are able to raise issues of concern and make formal complaints and have these heard.  The facility manager maintains the complaints register and this was current on the day of the audit visit. All formal complaints and concerns raised have been reported, recorded and responded to as described in the organisation’s policy. Complaint correspondence is sent within the timeframes of Right 10 and responses are respectful.  Documentation was reviewed in relation to a complaint made to the Health and Disability Commission shortly after the last onsite audit. It was closed in July 2015 with the commission satisfied with the actions taken by St Johns Hill in response to the complaint. The facility manager reported that the follow-up actions were reviewed by the district health board and the Ministry of Health in September 2015. These actions are referred to in 1.2.4 and 1.2.7.  Staff interviewed confirmed that their training includes the complaints process and that they receive information about complaints received by the facility. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Staff members receive training in the importance of providing information to residents and families and communication. Review of personnel files and interviews with staff members confirmed that this occurred. Staff interviewed confirmed that the training they receive provides them with appropriate information and to be able to communicate with residents and family members.  Residents’ files reviewed record communication with family members, discussions and formal transfer of information at different times when this is appropriate. Records were evident on a range of specific forms for this purpose and a general communication sheet for this purpose. Residents and family members interviewed confirmed that they receive information and are notified when appropriate and that staff communication is respectful.  Interpreter services can be accessed when needed. The organisation has appropriate policies and procedures to guide staff members to do this. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | There is a governance statement which includes the values, scope and goals of the wider organisation. This document was reviewed by the organisation’s area manager and is current.  The facility manager is a registered nurse and holds a current practising certificate. She has a range of relevant clinical nursing and management experience appropriate to her role at St Johns Hill. She has held the position since the current owners took over management of the facility in September 2013. She has a position description which provides her with the responsibility and accountability to undertake the role and has oversight and support from the area manager. Through interview she demonstrated her understanding of the requirements of her position, these standards and the contracts held by the facility. |
| Standard 1.2.3: Quality And Risk Management Systems  The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | There is a well described quality and risk management system which includes a current quality plan with quality objectives and a risk register. Both guide the activities of the management team and various committees and regular actions which are undertaken in the facility.  The organisation obtains its policies and procedures from an external contractor and these are tailored to the facility and kept up to date. Staff access documents through hard copies which are available throughout the facility. All versions sighted during the audit visit were current and a consistent version. Policies and procedures which require reference to and incorporation of interRAI requirements have these included.  There are regular meetings held each month which coincide with the area manager’s monthly visit to the facility. These are the general staff meeting, the registered nurses meeting and management team’s meeting (facility manager and clinical nurse leader). The latter two are with the area manager. In addition there is a two monthly health and safety meeting. At all of these meetings there are discussions of collated quality improvement data, corrective action plans, progress against the quality objectives, a six monthly review of the health and safety programme and annual review of the risk register. Quality management activity is an integral part of the facility’s routine and meeting minutes reviewed for 2016 and sampled from 2015 confirmed this.  The data is collated and benchmarked with the organisation’s Christchurch facility. The organisation has recently commenced benchmarking with an external organisation, which the facility manager reported is useful and provides another perspective when reviewing their data.  Interviews with the facility manager and clinical nurse leader confirmed that the meetings occur as documented. Other staff members interviewed reported that they receive information about quality improvement data and discuss trends, responses to specific events and promoting safety and wellbeing for residents at their meetings. |
| Standard 1.2.4: Adverse Event Reporting  All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner. | FA | The facility manager described her responsibilities for statutory reporting and essential notifications. She is primarily responsible for all notifications on behalf of the facility with copies of these to the organisation’s head office in Christchurch. Examples of notifications made since the last on site were reviewed.  All adverse events are reported and recorded by staff and examples were reviewed. Meeting minutes reflect discussion and planning of improvements to service delivery based on analysis of adverse events.  Discussion and review of data with the facility manager in relation to an external complaint confirmed that the corrective actions implemented as a result of the complaint have resulted in a reduction in falls with injury over time. (There has been no formal analysis or evaluation of the data). |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | FA | The facility manager is responsible for the recruitment and appointment of all new staff. This includes all aspects of appointment and selection, including reference checking and police vetting and using a formal interview process. For those staff members who are health professionals, this includes validation of their practising certificates and monitoring these annually thereafter. Contracted health and allied health professionals also have their professional registrations and practising certificates monitored, to ensure a safe standard of care is provided to residents.  A comprehensive orientation programme is used by the facility. It was reviewed and enhanced during 2015 as a result of the Health and Disability Complaint (noted in standard 1.1.13) and all existing staff completed the updated programme. New staff who have commenced work since September 2015 have all completed the new orientation programme. It covers a broad range of topics relevant to the aged care sector and includes competency assessments. The manager reported that this provides a more effective introduction for new staff.  The facility manager prepares an annual training plan based on a biennial list of topics. All topics are covered over a two year period. The inservice training includes refresher training, competency assessment and topics which are responses to issues which have arisen from individual adverse events or trends in adverse events. The in-service training programme is appropriate to the needs of the staff and residents’ needs, and is complemented by the completion of external training by staff when available.  All care givers complete the suite of Aged Care Education (ACE) certificates. Nursing staff maintain their professional development requirements and the facility has just introduced the use of the Whanganui District Health Board’s (WDHB) nursing performance appraisal which incorporates nursing competencies. Once completed the nursing staff have met the requirements of the professional development and recognition programme (PDRP). This appraisal document was sighted on the personnel files for the two nurses for whom it has been used so far. The nursing staff maintain an appropriate range of nursing skills, knowledge and competencies including, Hospice New Zealand palliative care modules, interRAI and syringe driver competency.  A selection of personnel files were reviewed during the audit visit. This selection included the facility manager and clinical nurse leader and a range of new and longer serving staff members. Files are well organised and maintained. There is ample evidence of the organisation’s human resource management processes being implemented, including a formal annual performance appraisal for all staff. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is an organisational policy on staffing and skill mix. The area manager uses the indicators for safe aged care staffing allocations guidelines and the facility manager uses both these documents to develop the rosters based on the number and acuity of residents at any time.  The facility manager develops the rosters at least two weeks in advance. There are adequate numbers of staff members with a mix of skills (nursing, care givers and house-keeping staff) to meet residents’ needs. At interview with the facility manager, she reported that the staff numbers can be increased if the mix of residents and their needs change.  There are currently nine registered nurses employed at the facility and seven have been trained and maintain their competency to undertake interRAI assessments. Each of these seven nurses has an allocation of residents whose care plans and assessments (including interRAI) they are responsible for. This enables the facility to largely remain up to date with their interRAI requirements. (See also 1.3.3.2). |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | The medication management policy is comprehensive and identifies all aspects of medicine management. A previous corrective action requiring the implementation of appropriate processes to manage medicine reconciliation has been addressed.  A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.  Controlled drugs are stored in separate locked cupboards. Controlled drugs are checked by two nurses for accuracy in administration. The controlled drug register evidenced weekly and six monthly stock checks and accurate records.  The records of temperature for the medicine fridge have readings documenting temperatures within the recommended range.  The GP’s signature and date are recorded on the commencement and discontinuation of medicines. The three monthly GP review is recorded on the medicine chart.  Residents who self-administer their own inhalers were not observed to have the required documentation in place to ensure this is managed in a safe manner and this requires attention.  Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors and compliance with this process was verified.  Standing orders are used and documentation is compliant with guidelines. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid Management  A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery. | FA | The food, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietician’s November 2015 assessment of the planned menu.  A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment to meet residents’ nutritional needs was sighted.  All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines.  The effectiveness of chemical use, cleaning, and food safety practices in the kitchen is monitored by an external provider. The facility receives monthly reports and recordings on the effectiveness of the programme. A cleaning schedule is sighted as is verification of compliance.  Evidence of resident satisfaction with meals was verified by observation, resident and family/whanau interviews and resident and family meeting minutes.  There are sufficient staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents as needed. The dining rooms are clean, warm, light and airy to enhance the eating experience. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Documentation, observations and interviews verified the provision of care provided to residents was consistent with residents’ needs and desired outcomes.  Residents and family/whanau members expressed satisfaction with the care provided.  There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents’ needs. |
| Standard 1.3.7: Planned Activities  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. | FA | An activities officer and diversional therapist provide activities to residents in each of the two wings of the facility. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. Activities assessments are analysed to develop an activities programme that is meaningful to the residents. The planned monthly activities programme sighted matches the skills, likes, dislikes and interests evidenced in assessment data. Activities reflect residents’ goals, ordinary patterns of life and include normal community activities. Family/whanau and friends are welcome to attend all activities. Group activities are developed according to the needs and preferences of the residents who choose to participate.  A residents’ meeting is held every two months and a family meeting every four months. Meeting minutes and satisfaction surveys evidence the activities programme is discussed and that management are responsive to requests. Interviews verified that feedback is sought and satisfaction with the activities offered. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Resident care is evaluated on each shift and reported in the progress notes. If any change is noted it is reported to the RN.  Care plan reviews verify formal care plan evaluations, following reassessment (using the interRAI assessment tool) occur every six months or as residents’ needs change and are carried out by the RN. Where progress is different from expected, the service is seen to respond by initiating changes to the care plan. This addresses a previous corrective action requirement.  A short term care plan is initiated for short term concerns, such as infections, wound care, changes in mobility and the resident’s general condition. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family/whanau are included and informed of all changes. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The facility is maintained in a safe, hygienic and tidy state. On the day of the audit visit it was clean, odour free and without clutter in corridors, all communal areas and residents’ rooms.  The environment has been built to promote mobility and independence for residents. Residents were observed to be moving around the facility throughout the day of audit either on their own, with assistance or using their mobility equipment. There are hand rails throughout and low-rolling resistance floor coverings.  Residents are able to access a range of external areas, with seating, shade and shelter. There are raised gardens and walkways with ramps and paving which promote access and use.  There is a current building warrant of fitness for the facility which expires 12 June 2016. |
| Standard 3.5: Surveillance  Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | In line with Health and Disability Services Standards (HDSS), Infection prevention and control standard (IC) (NZS 8134.3:2008), surveillance of infections is occurring as per the HDSS IC surveillance guide, and is the responsibility of the infection control nurse.  Daily incidents of infections and the required management plan are presented daily at handover, to ensure early interventions. Surveillance data is collated and analysed to identify any significant trends, possible causative factors and required actions.  Incidents of infections are presented at the staff and RN meetings and any ongoing corrective actions discussed, as evidenced by meeting records, infection control records and staff interviews. Incidents of infections are benchmarked internally within the organisation. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | On the day of the audit visit one resident was using an enabler. Their voluntary use of the equipment is recorded appropriately on their file, as required by the organisation’s policies and procedures. Records are maintained of monitoring, regular review of the consent and there is oversight by the facility’s restraint coordinator.  The resident’s safety and wellbeing are maintained with the use of the enabler and records on their file are current. |

# 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 1.3.12.5  The facilitation of safe self-administration of medicines by consumers where appropriate. | PA Low | Five residents were observed to self administer their inhalers. Three had the required paperwork filled out to verify competence; however no ongoing three monthly review of competence was documented for two of those residents. Two residents had no documentation verifying competence. | Residents are not facilitated to safely self administer their own inhalers, as per the company’s policy. | Residents requesting to self administer their medications are assisted to do so as per the company’s policy.  180 days |
| Criterion 1.3.3.3  Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer. | PA Low | A resident initially admitted for short term care, had not had an interRAI assessment completed within three weeks of being reassessed as requiring long term care. The interRAI assessments of another two residents had not been reviewed within the last six months. | The interRAI assessment is not always completed within the required timeframes. | InterRAI assessments of all residents are completed within the required timeframes.  180 days |

# Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

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| No data to display |

End of the report.