

Kowhai Resthome (2002) Limited

Introduction

This report records the results of a Surveillance Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by Health and Disability Auditing New Zealand Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Kowhai Resthome (2002) Limited
Premises audited:	Kowhai Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 7 April 2015 End date: 8 April 2015
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	28

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

Kowhai rest home provides rest home level care for up to 28 residents. There were 20 residents on the day of audit. The owner/manager is an experienced aged care manager and registered nurse (RN). Family and residents interviewed all spoke positively about the care and support provided. This unannounced surveillance audit was conducted against a sub-set of the relevant Health and Disability Standards and the contract with the District Health Board. The audit process included the review of policies and procedures, the review of residents and staff files, observations, and interviews with residents, family, management and staff.

The service has addressed three of four previous certification audit findings relating to documentation of family communication, care plan documentation, dietitian review, and medication management. An improvement continues to be required around documenting the reason for 'as required' medication use.

This audit identified further improvements required around aspects of food service, completion of annual appraisals, internal audit completion, resolution of corrective actions, GP admission, behaviour assessment completion and activities planning.

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.
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Communication with residents and families is appropriately managed. Complaints are actioned and include documented response to complainants. 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.		Some standards applicable to this service partially attained and of low risk.
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The manager is actively involved in management and resident care. She is supported by a part time registered nurse and an enrolled nurse. There is a quality and risk management system in place.

The quality management system included review and management of complaints, implementation of an internal audit schedule, incidents and accidents, review of infections through the surveillance programme, review of risk and monitoring of health and safety including hazards and maintenance (planned and reactive) to the building and grounds. There is a comprehensive orientation programme that provides new staff with relevant and specific information for safe work practice. The in-service education programme covers relevant aspects of care and support. The staffing levels provide sufficient and appropriate coverage for the effective delivery of care and support. Staffing is based on the occupancy and acuity of residents.

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.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for care plan development with input from residents and family. Residents and family interviewed confirmed that the care plans are consistent with meeting residents' needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. Overall medications are managed and administered in line with legislation and current regulations. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

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

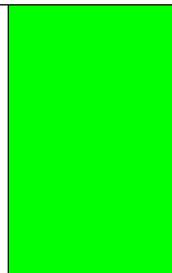


Standards applicable to this service fully attained.

Documentation of policies and procedures and staff training demonstrate residents are experiencing services that are the least restrictive. There are no residents requiring restraint or enablers.

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 type of surveillance undertaken is appropriate to the size and complexity of the organisation. Standardised definitions are used for the identification and classification of infection events.

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	12	0	5	0	0	0
Criteria	0	35	0	7	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
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The service has a complaints policy and procedure in place and residents and their family/whanau are provided with information on the complaints process on admission through the information pack. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. A complaints register is maintained with all documentation which shows that complaints are managed and resolved. Residents and family members advised that they are aware of the complaints procedure and how to access forms.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment</p>	FA	<p>There is open disclosure practiced at the facility. Resident files reviewed provided evidence of communication with families following adverse events involving the resident, or any change in the resident's condition. This was confirmed during interviews with family members. Six residents and three family members interviewed stated they are informed of changes in health status and incidents/accidents. This was confirmed on incident forms sampled. These are improvements since the previous audit. Residents and family members also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident/relative meetings take place and the manager and registered nurses have an open-door policy. Residents and family are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The service</p>

<p>conducive to effective communication.</p>		<p>has policies and procedures available for access to interpreter services and residents (and their family/whānau). If residents or family/whanau have difficulty with written or spoken English then the interpreter services are made available.</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>	<p>FA</p>	<p>Kowhai rest home provides rest home level care for up to 28 residents. There were 20 residents on the day of audit including one respite resident and one hospital level resident (evidence of MoH dispensation provided). There were eight residents on other non-aged care contracts. The Kowhai facility manager (RN) is a joint owner of the facility. She has been in the role on this site for over two years and has been a facility manager for 10 years. She is supported by an experienced clinical manager (RN) who has been in the role since the facility has been on this site and has extensive facility manager experience.</p> <p>The owner/manager states facility's scope, direction and goals of the facility are in place. The business plan, quality and risk management plan with mission statement, philosophy and goals for 2015 are completed.</p> <p>The manager and clinical manager attend DHB and Aged Care association study days and education sessions and have maintained at least eight hours annually of professional development activities related to managing a rest home.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality manual and the business, quality, risk and management planning procedure describe the Kowhai Rest Home's quality improvement processes. The risk management plan for 2015 was sighted and describes objectives, management controls and assigned responsibility. Progress with the quality and risk management programme has been monitored through the quality improvement meeting, and staff meetings. Monthly and annual reviews have been completed. Meeting minutes have been maintained and staff were expected to read the minutes and sign off when read. Minutes for all meetings have included actions to achieve compliance where relevant. Discussions with staff confirmed their involvement in the quality programme. Resident/relative meetings have been held. Data is collected on complaints, accidents, incidents, infection control and restraint use. The internal audit schedule for 2014 was not fully completed and corrective actions were not signed off when resolved. Areas of non-compliance identified at audits have been actioned for improvement. Specific quality improvements have been identified. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service has comprehensive policies/ procedures to support service delivery. Policies and procedures align with the client care plans. A document control policy outlines the system implemented whereby all policies and procedures are reviewed regularly. There is a Death/Tangihanga policy and procedure that outlines immediate action to be taken upon a consumer's death. Falls prevention strategies are implemented for individual residents. Residents' are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families Policies and procedures reflect current accepted good practice and reference legislative requirements. There is a system in place for reviewing and updating policies and procedures.</p>

		<p>Staff interviews confirm staff sign to demonstrate they have been updated on new/reviewed policies, and meeting minutes. Staff interviewed also confirmed the policies and procedures provide appropriate guidance for service delivery and they are advised of new policies / revised policies via handover and meetings.</p> <p>There are health & safety policies and procedures in place. There is a hazard reporting system in place. The hazard register records hazards for all areas of the service.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is a documented adverse event reporting system. Staff state they document adverse, unplanned or untoward events on an incident/accident form, which is then followed up by management and filed in resident files.</p> <p>Staff and management confirm during interviews, that they are made aware of their essential notification responsibilities.</p> <p>Monthly accident/incident analysis forms and incident forms for February and March 2015 were reviewed. The data includes date, time, and name of residents, accident type / location, injury and treatment required. Neurological observations were sighted for residents with unwitnessed falls or head injury. The forms were completed fully and followed up by the clinical or facility manager. Families were notified and the GP as indicated. Progress notes were completed when an accident or incident occurred and detailed any follow up required.</p> <p>There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring and corrective action to minimise and debriefing.</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 the requirements of legislation.</p>	PA Low	<p>The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and veracity. Staff files contain evidence of interview and reference checking, contract, orientation and education, job description and annual appraisal. Copies of practising certificates are kept. There are human resources policies including recruitment, selection, orientation and staff training. Six staff files were reviewed, not all files evidence annual appraisals. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed were able to describe the orientation process and stated that they believed new staff were adequately orientated to the service. Annual appraisals are conducted for all staff. There is a completed in-service calendar for 2014 and a plan for 2015 that has been commenced. Caregivers have completed or commenced the national certificate in care of the elderly. The manager and registered nurses attend external training including conferences, seminars and sessions provided by the local DHB</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>Kowhai has a four weekly roster in place which ensures that there is at least two staff members on duty at all times. A clinical manager and an enrolled nurse are employed. The full time manager is also a registered nurse and shares after hours and on-call with the clinical manager. Caregivers advise that sufficient staff are rostered on for each shift. All senior staff are trained in first aid. Staff, residents and relatives interviewed stated that there were sufficient staff rostered.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Low</p>	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. All clinical staff who administer medications have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The clinical manager, enrolled nurse and care staff interviewed were able to describe their role in regard to medicine administration. A contracted pharmacy supplies packed medications. Medications are managed appropriately in line with required guidelines and legislation with the exception of the self-medication competency and documentation of as required medications. Previous findings relating to documenting in the progress notes the reason why an as required medication is used continues to require improvement. Ten medication charts sampled met all the prescribing requirements. One resident who wishes to self-medicate inhalers has no competency assessment. Internal medication audits are conducted four monthly. Medication charts reviewed identified that the GP had seen the reviewed the resident three monthly.</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>PA Low</p>	<p>All meals at Kowhai are prepared and cooked on site. There is a four weekly menu last review by a dietitian in July 2014. This is an improvement since the previous audit. Meals are prepared in a kitchen adjacent to the main dining room for serving. Cooks and kitchen staff are trained in safe food handling and food safety procedures are adhered to. There is food available for residents outside of meal times. Residents who require special eating aids are provided for to promote independence. Resident dietary profiles and likes and dislikes are known to food services staff and any changes are communicated to the kitchen via the senior staff. A dietitian is available via referral to review residents. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by the dietitian. Resident meetings and surveys allow for the opportunity for resident feedback on the meals and food services generally. Interviews with residents and family members indicate satisfaction with the food service. Food temperatures are not being monitored and decanted food is not being dated.</p>

<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>All residents are admitted with a care needs level assessment completed by the needs assessment and service coordination team prior to admission. Personal needs information is gathered during admission which formed the basis of resident goals and objectives. Assessments are reviewed at least six monthly. Appropriate risk assessments had been completed for individual resident issues. The previous shortfall in relation to assessments is now resolved.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>A written record of each resident's progress is documented. Changes are followed up by the registered nurse (evidenced in all residents' progress notes sighted). When a resident's condition alters, the registered nurse initiates a review and if required, a GP consultation or referral to the appropriate health professional is actioned. The staff interviewed advised that they have all the equipment referred to in care plans necessary to provide care. Dressing supplies are available and the treatment room is well stocked for use. Wound documentation was reviewed and included wound assessment, treatment plans and evaluations and progress notes for all wounds. The wound care nurse specialist advice is readily available. Continence products are available and specialist continence advice is available as needed. Short term care plans with interventions and on-going evaluations by the RN were evidenced. A physiotherapist referral is initiated if required.</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>	<p>FA</p>	<p>The activities coordinator at Kowhai provides an activities programme over five days per week. Group activities are voluntary. Residents are able to participate in a range of activities that are appropriate to their capabilities. Kowhai has a van which is used for resident outings at least once a week.</p> <p>The group activity plans are displayed on notice boards around the facility and each resident has a copy in their room. All residents who do not participate regularly in the group activities are visited for one to one sessions, with records kept to ensure all such residents are included.</p> <p>All interactions observed on the day of the audit indicated a friendly relationship between residents and activity coordinator. Each resident has an assessment on admission which forms the basis of the activities plan. One resident admitted did not have an activities plan (#link 1.3.3.3). The resident files reviewed included a section of the long term care plan for activities, which has been reviewed at the six monthly care plan review. Residents interviewed spoke very positively of the activity programme with feedback and suggestions for activities made via meetings and surveys</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Initial care plans are evaluated within three weeks of admission. Long term care plans are reviewed and evaluated by the registered nurse at least six monthly or when changes to care occur as sighted in the files reviewed. A multi-disciplinary team meeting is conducted six monthly for each resident and involves all relevant personnel. The GPs examine the residents and review the medications three monthly. Short term care plans focus on acute and short term needs and are regularly evaluated, resolved or written into the long term care plan as an on-going problem</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>Kowhai rest home displays a current building warrant of fitness which expires on 1 April 2016.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Infection surveillance and monitoring is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered on to a monthly facility infection summary and staff are informed at the monthly staff meeting. This data is monitored and evaluated monthly and annually. There has not been an outbreak at the facility since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively</p>	<p>FA</p>	<p>Documented systems are in place to ensure the use of restraint is actively minimized. The facility was not utilising restraint or enabler use on audit days. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. The restraint use, education and audits are reviewed at quality meetings.</p>

minimised.		
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	There is a comprehensive annual internal audit schedule in place which was partially completed for 2014 and a schedule in place for 2015. Areas of non-compliance identified through quality activities are documented as corrective actions, implemented and reviewed for effectiveness. Quality and staff meetings discuss audit results and areas requiring corrective action.	Twelve internal audits scheduled to be completed in 2014 were not completed.	<p>Ensure internal audit schedule is completed.</p> <p>90 days</p>
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and</p>	PA Low	When shortfalls are identified a corrective action plan is developed which includes the actions required and timeframes.	Five corrective actions were not dated and signed when resolved.	<p>Ensure corrective actions signed and dated when resolved.</p> <p>90 days</p>

implemented.				
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	An annual education plan is on place and there was evidence that 2014 plan was completed. Monthly topics are scheduled to coincide with the monthly staff meeting and cover compulsory education as per the DHB contract and other topics relevant to the current residents.	Four of six staff files did not have a current appraisal.	<p>Ensure all staff have an annual appraisal completed.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Low	Kowhai rest home has a medicine management system established to provide safe and appropriate medication a management. Medication charts are completed fully by the GP and reviewed at least three monthly. The medication charts contain identification photos and allergies are documented. Staff administering medication complete annual competency assessments. Medication storage, disposal and reconciliation comply with legislation and guidelines.	The reason for giving as required medications is not documented in the progress notes, this was a previous finding.	<p>Ensure that when an 'as required' medication is administered that reason is documented in the progress notes, so that effectiveness can be followed up.</p> <p>60 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	PA Low	There are policies and procedures in place for safe medicine management that meet legislative requirements.	One resident who self-medicates inhalers does not have a competency assessment.	<p>Ensure all residents who self-medicate have a competency assessment completed.</p> <p>30 days</p>
<p>Criterion 1.3.13.5</p> <p>All aspects of food</p>	PA Low	There are policies and procedures in place for safe food handling that meet legislative requirements. All food is cooked on site and served directly to the	Food temperatures are not being monitored. Decanted foods are not being dated	<p>Ensure monitoring the food</p>

<p>procurement, production, preparation, storage, transportation, delivery, and disposal comply with current legislation, and guidelines.</p>		<p>residents in the adjoining dining room. Residents and relatives interviewed reported that the food is of a high standard and meets the residents' needs. Individual likes and dislikes are documented to ensure the staff member serving accommodates these. A seasonal, dietitian approved menu is provided.</p>	<p>when containers filled.</p>	<p>temperatures is undertaken prior to serving. Date all containers when foods have been decanted into them.</p> <p>90 days</p>
<p>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.</p>	<p>PA Low</p>	<p>Timeframes are set for assessments and planning at all stages of the residents care. Initial assessments and care plans are completed within 48 hours. Long term care plans are completed within three weeks and reviewed six monthly or as required when health status changes.</p>	<p>One resident does not have the behaviour assessment fully completed or signed on admission. One resident was not assessed by the GP until eight days after admission. One resident admitted in December 2013 did not have an activities plan.</p>	<p>Ensure all resident assessments are completed and signed, GP admissions are completed within 48 hours and activities plans are completed for all residents.</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.