

Radius Residential Care Limited - Radius St Winifreds Hospital

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: Radius Residential Care Limited

Premises audited: Radius St Winifreds Hospital

Services audited: Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Residential disability services - Physical

Dates of audit: Start date: 27 January 2016 End date: 28 January 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: 40

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Radius St Winifred's is part of the Radius Residential Care Group. St Winifred's cares for up to 92 residents requiring hospital, psychogeriatric and residential disability level care. However, on the day of the audit 40 beds are currently closed. This is due to repairs being undertaken on damage suffered in the Canterbury earthquakes. On the day of the audit there were 40 residents.

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, relatives, staff and management.

The facility manager has extensive experience managing residential health services and has been in the role since December 2015. She is supported by the Radius regional manager and a clinical nurse manager. The clinical nurse manager has been in the role since November 2015 and is currently completing orientation.

Residents and family interviewed spoke positively about the service provided.

Both of the two shortfalls identified in the previous audit have been addressed. These were around care planning and medication administration. This audit has identified shortfalls around interRAI assessments, expired medications and corrective action 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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There is evidence that residents and family are kept informed. A system for managing complaints is in place. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service.

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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Services are planned, coordinated, and are appropriate to the needs of the residents. A facility manager is responsible for the day-to-day operations of the facility. Quality and risk management processes are undertaken. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and robust health and safety processes. Adverse, unplanned and untoward events are responded to in an appropriate and timely manner. Human resources are managed in accordance with good employment practice, meeting legislative requirements. An orientation programme is in place for new staff. The education and training programme for staff is embedded into practice. Registered nursing cover is provided twenty four hours a day, seven days a week. There are adequate numbers of staff on duty to ensure residents are safe.

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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Initial assessments and risk assessment tools are completed by the registered nurses on admission. Registered nurses are responsible for care plan development with input from residents and family and care plans document interventions for all identified needs. Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the activities programme. 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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A current building warrant of fitness is posted in a visible location. Hazards during the building repairs are identified, documented and managed.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

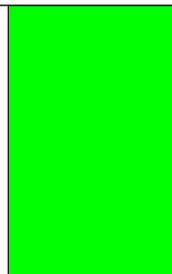


Standards applicable to this service fully attained.

The service has alternative systems available so that staff can use restraint as a last resort strategy. There were six with restraint and three residents voluntarily using bedrails as enablers on the day of the audit. Care plans include reference to the use of 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.

St Winifred's has an infection control programme that complies with current best practice. Infection control surveillance is established that is appropriate to the size and type of services. There is a defined surveillance programme with monthly reporting by the infection control coordinator.

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	14	0	3	0	0	0
Criteria	0	37	0	3	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 that describes the management of the complaints process. Complaints forms are accessible to residents and family. Information about complaints is provided on admission. Interviews with three residents (all hospital level – no other residents were able to be interviewed due to health status or cognitive ability) and family members confirmed their understanding of the complaints process. Care staff interviewed (four healthcare assistants including two from the psychiatric unit and two from the hospital units, two registered nurses (one from the psychogeriatric unit and one from the hospital) and one activities coordinator were able to describe the process around reporting complaints.</p> <p>The complaints register includes verbal and written complaints with evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, meeting time lines, corrective actions when required, and resolutions.</p> <p>Five complaints sampled from 2015 and the one complaint to date in 2016 were managed within the required time frames as determined by the Health and Disability Commissioner. Complaints are linked to the quality and risk management system.</p>
<p>Standard 1.1.9: Communication</p>	FA	<p>An open disclosure policy describes ways that information is provided to residents and families. The admission pack contains a comprehensive range of information regarding the scope of service provided to the resident and</p>

<p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>		<p>their family on entry to the service and any items they have to pay that is not covered by the agreement. Regular contact is maintained with family including if an incident or care/ health issues arises. Five families (two from the hospital and three from the psychogeriatric unit) interviewed stated they were kept well informed. Ten incident/accident forms were reviewed and identified that the next of kin were contacted or if not, justification as to why. Residents' meetings are held two monthly.</p> <p>The service can access interpreter services through the District Health Board. The information pack is available in large print and can be read to residents. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Radius St Winifred's is part of the Radius Residential Care Group and provides care for up to 93 residents requiring hospital, psychogeriatric and residential disability levels of care. The service has required significant repairs following the Canterbury 2011 earthquakes and these are being undertaken in a graduated manner. On day of audit there were 40 beds occupied from a total of 53 functional beds with 40 beds closed due to EQC repairs. On the day of the audit there were 20 psychogeriatric level residents (including one resident on a younger persons with disabilities contract and three residents under long term chronic health conditions contracts) and 20 hospital residents (including three residents on younger persons with disabilities contracts and three residents on long term chronic conditions contracts).</p> <p>The Radius St Winifred's business plan April 2014 to March 2017 is linked to the Radius Care Group strategies and business plan targets. The mission statement is included in information given to new residents. An organisational chart is in place. Comprehensive quarterly reviews are undertaken to report on achievements towards meeting business goals.</p> <p>The facility manager (non-clinical) began employment in the role in December 2015, having managed a residential health facility for 18 years prior to that. She is supported in the management role by the regional manager. The clinical nurse manager, who has significant aged care clinical management experience, was employed in November 2015. Both the facility manager and the clinical manager have undertaken orientation with the clinical nurse manager continuing to be orientated by the regional manager.</p> <p>The facility manager has maintained more than eight hours of professional development activities related to managing an aged care facility.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an</p>	<p>PA Low</p>	<p>A quality and risk management system is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Policies and procedures have been updated to reflect the implemented InterRAI procedures.</p>

<p>established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The monthly collating of quality and risk data includes monitoring clinical effectiveness, work effectiveness, risk management/falls, and consumer participation. Data is collated and benchmarked against other Radius facilities. A resident satisfaction survey is conducted each year. Results for 2015 reflected satisfactory levels of resident satisfaction with the services received. An annual internal audit schedule confirmed audits are being completed as per the schedule. Corrective actions are developed where opportunities for improvements are identified. There is evidence of corrective actions being communicated to all staff but not always evaluated and signed off by management when completed.</p> <p>Falls reduction strategies include staff knowing the residents who are at risk, managing challenging behaviours effectively, adhering to residents' routines and anticipating their needs, and intentional rounding with frequencies determined by the resident's risks of falling. All healthcare assistants utilise transfer belts to minimise resident harm from falls.</p> <p>Processes are in place for accident and incident reporting, injury prevention and management, workplace inspections, and hazard management.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	<p>FA</p>	<p>The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident information. The reporting system is integrated into the quality and risk management programme. Once incidents and accidents are reported, the immediate actions taken are documented on incident forms. Ten incident forms sampled from January 2016 indicated that the incident forms are then reviewed and investigated by a registered nurse. If risks are identified these are processed as hazards using a hazard identification form. Accidents and incidents are firmly embedded into quality and risk management systems.</p> <p>A discussion with the facility area regional managers has confirmed their awareness of statutory requirements in relation to essential notification. The DHB was notified following a fracture in December 2015 and Public Health were notified of an outbreak in January 2016.</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</p>	<p>FA</p>	<p>There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of health professionals are current. Five staff files were reviewed (the clinical nurse manager, an activities coordinator, two healthcare assistants and a registered nurse). Evidence of signed employment contracts, job descriptions, orientation, and training were available for sighting. Annual performance appraisals for staff were completed in files sampled. Newly appointed staff complete an orientation that is specific to their job duties. Interviews with care staff described the orientation programme that includes a period of supervision.</p> <p>The service has a training policy and schedule for in-service education. The in service schedule is implemented</p>

<p>requirements of legislation.</p>		<p>and attendance is recorded. All staff complete a range of competency assessments. There are 17 healthcare assistants who work in the psychogeriatric unit. Ten have completed the required dementia standards, five who have been employed for less than one year are currently enrolled and completing the standards and two who have worked for the service for less than six months are in the process of enrolling with the support of the education facilitator. All registered nurses have current first aid/CPR certificates.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. The clinical nurse manager is a registered nurse and works 40 hours per week. There is one registered nurse on duty in each of the hospital and psychogeriatric units at all times. Due to current renovations, the hospital is divided into two sections. The sections are not joined and do not have linking call bells. One registered nurse works between the two wings and one care healthcare assistant is on duty in each wing between 1 pm and 3 pm and from 10 pm until 7 am. The service has identified the risk of a sole caregiver not being able to alert others to the need for urgent assistance despite always carrying a telephone and has developed a plan to manage this until the building is completed. The service has purchased walkie talkies so that the healthcare assistants on the two wings can communicate at any time if necessary.</p> <p>Staff reported that staffing levels and the skill mix was appropriate and safe since the purchase of the walkie talkies. All families and residents interviewed advised that they felt there was sufficient staffing. The roster is able to be changed in response to resident acuity.</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>Medications are checked against the doctor's medication profile on arrival from the pharmacy by an RN. Any mistakes by the pharmacy are regarded as an incident.</p> <p>Designated staff are listed on the medication competency register which shows signatures/initials to identify the administering staff member. Two registered nurses were observed safely and correctly administering medications.</p> <p>Resident medication charts sampled (10) were identified with demographic details and photographs. Medication fridges are monitored daily. All 10 medication charts had allergies (or nil known), documented.</p> <p>All medications are stored appropriately, however, not all medications were noted to be within expiry dates. Ten medication signing sheets reviewed (six hospital and four psychogeriatric) had documented evidence of medications being signed for when administered. This is an improvement on the previous certification audit</p> <p>Nine of ten (one resident had been at the service less than three months) medication charts reviewed identified that the GP had seen the reviewed the resident three monthly and the medication chart was signed. All 10 medication charts indicate medication is being administered as prescribed. All medication charts document the</p>

		indication for giving the 'as required' medication. All eye drops were dated on opening.
<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 large workable kitchen. The kitchen is a commercial kitchen operated by a contracted company and also provides meals for other residential services. The kitchen and the equipment are well maintained. The service employs sufficient kitchen staff to provide meal services over seven days a week. There is a rotating four weekly menu in place that is designed by a dietitian. Diets are modified as required. There is a choice of foods and the kitchen can cater to specific requests if needed.</p> <p>Food safety information and a kitchen manual is available in the kitchen. Food served on the day of audit was hot and well presented.</p> <p>The residents interviewed spoke positively about meals provided and they all stated that they are asked by staff about their food preferences.</p> <p>The service has a process of regular checking of food in both the fridge and freezers to ensure it is disposed of when use by date expires. All food is stored and handled safely. Food temperatures are recorded. The kitchen is clean.</p> <p>Kitchen staff have been trained in safe food handling.</p> <p>The service caters for the needs of younger residents and those identified as weight loss or risk of weight loss.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>In all five resident files reviewed (three hospital and two dementia) the long term care plans documented detailed interventions to guide staff. This is an improvement on the previous certification audit.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their</p>	FA	<p>The care being provided at St Winifred's is consistent with the needs of residents as demonstrated on the overview of the care plans, discussion with family, residents, staff and management. Short term care plans, turning charts, food and fluid records and behaviour monitoring charts were evident. In all files sampled the residents are receiving care that meets all their needs. Behaviour management was well documented in the psychogeriatric unit files sampled.</p> <p>Dressing supplies are available. The service has taken a proactive approach to pressure injury prevention and all</p>

<p>assessed needs and desired outcomes.</p>		<p>residents who are identified as a potential risk of developing a pressure injury are logged into the wound review process. Each potential pressure injury is reviewed, a plan in place and regularly evaluated to prevent further deterioration. There were five residents (including the hospital tracer) who have a potential for pressure injury wound care plan.</p> <p>Wound assessment and wound management plans are in place for five residents with wounds, including skin tears to one pressure injury. There was also documented evidence of assessments, wound management and evaluations completed for the hospital tracer resident who had a recently healed pressure injury (grade one).</p> <p>All wounds have documented assessments and a treatment plan in place. All wounds show evidence of healing.</p> <p>Contenance 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 and this could be described.</p> <p>Registered nurses interviewed were able to describe access to specialist services 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>There is one diversional therapist and two activity officers who work in the facility across all service levels. All recreation/activities assessments and reviews are up to date. On the day of audit, residents were observed being actively involved with a variety of activities in the main lounge and throughout the facility. Residents have a comprehensive assessment completed over the first few weeks after admission obtaining a complete history of past and present interests, career and family.</p> <p>Activities are age appropriate (including to meet the need of younger residents) and have been comprehensively planned. Activities provided are meaningful and reflect ordinary patterns of life. Healthcare assistants provide activities and stimulation in the psychogeriatric unit when activities staff are not</p> <p>All residents and family members interviewed stated that activities are appropriate and varied and spoke positively about the programme.</p> <p>Five resident files reviewed identified that the individual activity plan is reviewed at the time of the care plan review.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a</p>	<p>FA</p>	<p>All initial care plans are evaluated by the registered nurses within three weeks of admission. Files sampled demonstrated that the long term care plan was evaluated at least six monthly or earlier if there is a change in health status. There was at least a three monthly review by the GP. In files sampled all changes in health status were documented and followed up. Care plan reviews are signed by an RN. Short term care plans are evaluated and resolved or added to the long term care plan if the problem is on-going as sighted in resident files sampled.</p>

comprehensive and timely manner.		Where progress is different from expected, the service responds by initiating changes to the care plan.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is posted in a visible location (expiry date 1 January 2017). The identified risks related to the building process have been identified and managed with all construction areas unable to be accessed.
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	The surveillance of infection data assists in evaluating compliance with infection control practices. Infections are collated monthly and this data is reported to the facility meetings. Monthly data was seen in staff areas. The service submits data monthly to Radius head office where benchmarking is completed. There has been one outbreak since the previous audit which was managed well and contained to five residents and three staff in one hospital wing.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The use of restraint is regarded as a last intervention when all other interventions or calming/defusing strategies have not worked. There is a regional restraint group at the organisational level and a restraint group at the facility where restraint is reviewed. There were three residents with enablers in the form of bed rails in the hospital. These were requested by the residents. The assessment process ensures enablers are voluntary and the least restrictive option. This was evident in review of one of the files of a resident using an enabler. There were six residents using restraints.

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 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	Corrective action plans have been documented when service shortfalls are identified through internal audits or other quality management processes. Fifteen corrective action plans were developed in 2015 but only seven were signed off as implemented. Staff interviewed reports issues are addressed when they are identified.	Eight of the fifteen corrective action plans developed in 2015 have not been signed off as completed.	<p>Ensure corrective action plans are implemented and signed out when completed.</p> <p>90 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is</p>	PA Low	The service uses blister packed medication and individually dispensed medication at ward stock, these are checked on arrival by a registered nurse and any pharmacy errors are	There were four expired medications found in the	Ensure that medications are regularly

<p>implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>recorded and fed back to the supplying pharmacy. Medications are stored in locked cupboards in a locked room. All medications in the hospital cupboard were current but there were expired medications in the psychogeriatric cupboard.</p> <p>Staff sign for administration of medication on medication sheets. The medication folders include a list of specimen signatures and competencies. All 'as required' medication charted includes an indication for use.</p>	<p>psychogeriatric unit medication cupboard.</p>	<p>checked and all expired medications are returned to pharmacy.</p> <p>60 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>All resident files reviewed had a comprehensive suite of assessments completed, including behavioural, falls and pressure area risk (Waterlow). All assessments have been signed and dated by the registered nurse and reviewed six monthly, or more often as condition changed. The interRAI assessment tool has not been fully utilised for all new residents.</p>	<p>Four of the five files sampled were for residents admitted since 1 July 2015. Three of these four files did not have an interRAI assessment completed.</p>	<p>Ensure all new residents have an interRAI assessment completed within 21 days of admission.</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.