# Elsdon Enterprises Limited - Bradford Manor

## 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](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:** Elsdon Enterprises Limited

**Premises audited:** Bradford Manor

**Services audited:** Dementia care

**Dates of audit:** Start date: 7 March 2017 End date: 8 March 2017

**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:** 25

# 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

Bradford Manor is part of the Elsdon Enterprises Group. The service is certified to provide dementia level of care for up to 26 residents. On the day of audit there were 25 residents.

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

A non-clinical manager is responsible for the day-to-day running of the home, with clinical oversight provided by an experienced registered nurse. Bradford Manor has a quality assurance and risk management programme in place. The activities programme is varied and designed to meet the needs of residents.

The service had completed an extensive refurbishment since the previous audit. This has included painting, carpeting and re-furnishing. Families and the general practitioner interviewed commented positively on the standard of care, refurbishment of the facility and services provided at Bradford Manor Rest Home.

The service had addressed the one previous audit finding around high hot water temperatures and testing and tagging of electrical equipment.

This audit identified improvements required around updating H&S policy, interRAI assessments, and medication management system.

## 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. |

There is a policy to guide staff around open disclosure. Families are advised of incidents and accidents and this is recorded in progress notes and in the family contact sheet.

The manager leads the investigation of any concerns/complaints and the complaint’s register is up to date.

## 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. |

Bradford Manor has a quality assurance and risk management programme. The manager has maintained at least eight hours annually of professional development related to managing a rest home. The quality plan is implemented. Data is evaluated and results used for quality improvement. The service maintains a risk register and a hazard register.

There are human resources policies to support recruitment practices. Performance appraisals are up to date. The education planner covers compulsory education requirements as well as additional subjects. The registered nurse (RN) has completed interRAI training.

There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There is a minimum of two caregivers on duty at any one time.

## Continuum of service delivery

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

An experienced registered nurse is responsible for each stage of service provision at the facility. Communication with family is documented. Short-term care plans are in use for changes in health status. Activities are provided that are meaningful and ensure that the resident maintains involvement in the community. All staff have completed annual competencies for medication administration. There are three-monthly GP medication reviews. Food services are now provided in-house. Dietary requirements are provided where special needs are required.

## 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. |

There is a current building warrant of fitness.

## Restraint minimisation and safe practice

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

The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. The registered nurse is the restraint coordinator. There are no residents using enablers or restraints.

## 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 registered nurse is the infection control coordinator. Surveillance of infections occurs and outcomes of these are communicated to staff.

## 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 | 13 | 0 | 2 | 1 | 0 | 0 |
| **Criteria** | 0 | 37 | 0 | 2 | 1 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](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).

|  |  |  |
| --- | --- | --- |
| **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 service has a complaints policy that describes the management of the complaints process. The manager leads the investigation of any concerns/complaints. Complaints forms are available and information about complaints is provided on admission. Interviews with family members confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints.A complaint’s register is maintained. There was one complaint documented for 2016; there is a Health and Disability Service letter confirming resolution of the issues raised. There were no other complaints documented for 2016.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a policy to guide staff on the process around open disclosure. A review of 10 incident and accidents forms evidenced that family are notified following an incident and changes in health status. Family interviewed stated they were kept informed. Two registered nurses (RNs) interviewed also confirmed that open disclosure principles are implemented.Family members stated they were welcomed on entry and were given appropriate time and explanation about services and procedures. Families are involved in the initial care planning and in ongoing care. Relative’s survey is conducted once a year and all feedback has been positive. The manager and the clinical lead/RN operate an open-door policy and this was observed on both days of the audit. Interpreter services are accessible via the local DHB.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Bradford Manor is owned by the Elsdon Enterprises Group and provides care for up to 26 rest home dementia level of care residents, occupancy on the day of audit was at 25. There were no respite residents on the day of audit and one resident was under the age of 65. A non-clinical manager is responsible for day-to-day running of the home, with clinical oversight provided by an experienced registered nurse (clinical lead). There is a quality assurance and risk management/business plan for 2017 that includes a mission statement and operational objectives. There is a risk management schedule and documented quality objectives that align with the identified person centred values and philosophy of the service. The manager has maintained at least eight hours annually of professional development activities related to managing a rest home.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The service has a quality assurance and risk management and business plan for 2017. There are three-monthly quality/staff meetings which include discussion around: internal audits, complaints, incident and accident analysis, infection control analysis, restraint and education. Feedback and progress relating to quality and risk management systems is provided during quality/staff meetings and to the owners via the manager. Discussions with two RNs and three caregivers confirmed their involvement in the quality programme. Resident/relative meetings no longer take place as attendance was minimal. The manager confirmed that discussions are held with residents and families on a regular but informal basis. Resident’s progress notes include family contact and related discussions. Family members confirmed that they are able to discuss any issues or matters of concern with management on a daily basis.The policies and procedures are scheduled to be reviewed on bi-annual basis but health safety policies have not been updated following legislative changes. The service has a health and safety management system. Security and safety policies and procedures are in place to ensure a safe environment is provided. Emergency plans ensure appropriate response in an emergency. Health and safety is discussed at the staff/quality meetings. There is an implemented annual staff training programme based around policies and procedures. Records of staff attendance are maintained. A document control system is in place. Documents no longer relevant to the service are removed and archived. The service collects information on resident and staff incidents and accidents. Incident/accident forms are completed and given to the RNs who complete a follow up. All incident/accident forms are seen by the manager. The manager completes any additional follow up and collates and analyses data to identify trends. Monthly and yearly data were sighted. Infection control data is collated monthly and reported to staff. Staff interviewed were knowledgeable around infection prevention and control. Formal review of the quality programme takes place annually. Corrective actions are documented and implemented as needed. Annual relative satisfaction surveys are conducted and all feedback in 2016 was positive.  |
| 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 | Individual incident/accident reports are completed for each incident/accident by the staff, with immediate action noted by the care staff on duty. The clinical lead/RN follows up on any clinical issues. Staff interview confirmed that the manager and clinical manager are available after hours as needed.A monthly review of all incidents and accidents is conducted and an annual review has been completed for 2016. Ten incident and accident forms were reviewed for this audit, all documented that an appropriate clinical response has been conducted including follow up as needed. The manager signs off on all incident and accidents. Minutes of the quality/staff meetings reflect a discussion of incidents/accidents and actions taken.Discussions with the clinical lead/RN and the manager confirms their awareness of the requirement to notify relevant authorities in relation to essential notifications. |
| 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 | Recruitment and staff selection processes were implemented. Five staff files were reviewed (one registered nurse, one diversional therapist and three caregivers) and all had appropriate documentation. A copy of practising certificates for RNs are maintained. Staff turnover was reported as low. The service has an orientation programme that provides new staff with relevant information for safe work practice. Staff interviewed could describe the orientation process and stated that new staff are adequately orientated to the service. Annual appraisals are conducted for all staff. One staff who was employed in November has a documented three-month follow-up performance appraisal. An in-service schedule has been implemented for 2016. Four staff completed external study days relating to dementia care. The clinical lead/RN attended external training including seminars and education sessions with the local district health board (DHB) which included wound care and pressure injury training.Discussion with both RNs and three caregivers confirm that the training programme is implemented and it covers relevant aspects of care and support. The annual training programme exceeds eight hours annually. There are eleven caregivers employed at Bradford Manor; all but two have completed the required dementia unit standards. These two have been employed less than a year. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | Sufficient staff are rostered on to manage the care requirements of the residents. The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is an RN on duty Monday to Sunday and on call after hours. The clinical lead RN works Monday to Friday for 35 hours per week and another RN works 16 – 20 hours per week and covers the weekends. There is a minimum of two caregivers on duty at any one time. The manager works every second Sunday and is available on-call. Interviews with staff and family members identified that staffing is adequate to meet the needs of residents.The RN is on call for clinical issues. Staff interviewed confirmed that they do access the RN support on weekends and afterhours and they are encouraged to use on call availability. Incident and accident reports reviewed showed that in two occasions, the RN input was obtained in assessment of a residents’ medical condition. Interview with the RN confirmed on call availability and stated that staff mostly required a phone advice and she follows it up the next day. The on-call is triaged by the manager. Staff phone the manager, the manager in-turn calls the RN to contact the home to follow up clinical issues. Staff were happy was this arrangement and supported that RN support is available when required  |
| 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 Moderate | The service uses individualised medication blister packs. The medications are delivered monthly and checked in by the RNs or a senior medication competent caregiver. A caregiver was observed administering medications to the residents at a lunchtime medication round and followed correct administration procedures. All medications are stored securely. The medication fridge is monitored and recorded daily.Medication reconciliation is completed on admission. Resident photos and allergies (or nil known allergies) are recorded on all 10 drug charts reviewed. An annual medication administration competency is completed by caregivers who have the responsibility of administering medications. Medication charts are legible, signed and dated by the prescriber and meet acceptable good practice standards. As required medication orders (PRN) all record indications for use. Advised by the RN that no PRN medication is given by caregivers without authorisation from the RNs. Review of five files and ten medication charts showed that PRN medication was used rarely and RN follow ups were recorded as required. Not all medications have been signed as given on administration.Ten of ten medication charts reviewed identified that the GP had reviewed the resident three-monthly and the medication chart was signed.The service has a policy and procedure around resident self-medicating, however, self-medicating is actively discouraged due to the cohort of residents. There were no residents self-medicating at Bradford Manor on both days of audit. |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | There is a small domestic style kitchen which is sufficient to cook for 26 residents. Bradford Manor has changed from contracted kitchen staff to in-house meal services since the previous audit. A cook has been employed and they are currently advertising for the second cook. In the meantime, one of the registered nurses undertakes this role. Policies/procedures for food services and menu planning are appropriate for the service. Bradford Manor uses a menu from a sister company and it is reviewed by a dietician. A dietary assessment is made by the RN, as part of the assessment process and this includes likes and dislikes. There was evidence of residents receiving supplements. Fridge and freezer temperatures are monitored and recorded daily in the kitchen. Food in the fridge and freezers is covered and dated. Special or modified diets are catered for. Soft and puree dietary needs are documented. Families interviewed were complimentary of the food services. On the both days of the audit, it was observed that food was well presented, freshly cooked and residents who required assistance had support from the staff. Nutritional supplements are available. Finger foods are available for residents 24/7.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Care plan interventions were current and significant changes updated as required. Communication with family is documented on the family/whānau consultation sheet or in progress notes. Continence products are available and resident files include a urinary continence assessment. Specialist continence advice is available as needed and this could be described by the registered nurse. Monthly weighs have been completed in all five files sampled. Referral to dietitian occurs as required as confirmed by the clinical lead/RN interview. Dressing supplies are available and the treatment rooms are stocked for use. Wound assessments and management plans have been completed for seven wounds which include six skin tears and one chronic skin ulcer. There was evidence of referral to the GP and district nurse relating to wound care. Short-term care plans are in use for changes in health status. Monitoring occurs for vital signs and blood glucose as needed.When a resident's condition alters, the clinical lead/RN initiates a review and if required, arranges a GP visit. There is evidence of three-monthly medical reviews or earlier for health status changes. Families interviewed confirmed care delivery and support by staff is consistent with their expectations. Families stated that they were kept informed of any changes to a resident’s health status. Three caregivers interviewed stated there is adequate equipment provided including continence and wound care supplies.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | Bradford Manor employs a diversional therapist (DT) who covers Monday to Friday, additional staff are rostered to cover weekends. The programme is planned monthly and residents and family have input into activities provided. Individual and group activities are catered for. The service has a van for outings and community connections were maintained through outings and invitation to in-house entertainment. Resident’s current and past interests were identified on admission and this information is used to plan individual and group activities. Individual participation in activities are recorded.Family interviews showed satisfaction with the programme. Staff are also involved in the delivery of the activities programme in the morning until the DT commences her duties. Resident files reviewed identified that the individual activity plan is reviewed at the care plan review. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Care plan evaluations reviewed were not up to date (link 1.3.3.3). Written evaluations showed the degree of achievement or expected outcomes related to each aspect of the long-term care plan interventions. Significant changes in resident’s condition are documented well and interventions have been updated. Short-term care plans are in use and used for wounds, infections and behaviour management.  |
| 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 building has a current warrant of fitness. Since the previous audit, the service completed an extensive refurbishment. This included painting, wall papering, carpeting and re-furnishing. Families and the GP interviewed commented positively on refurbishment of the facility and the care and attention during refurbishment. Hot water temperatures are checked monthly by the maintenance staff and all recordings were within the acceptable limit of 45 degrees Celsius or below. Medical equipment has been calibrated. Test and tagging of electrical appliances were also current. Therefore, required corrective actions from the previous audit have been addressed.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The clinical lead/RN is the infection control coordinator. Surveillance of infections occurs and outcomes of these are communicated to staff. Infection control data is collected monthly and analysed and outcomes of these were communicated to staff through staff meetings and handovers. Visitors are asked not to visit if they have been unwell. There are hand sanitisers throughout the facility and adequate supplies of personal protective equipment. There was an outbreak in August 2016 and staff and the clinical lead/RN described the learnings and improvements following the outbreak. On the day of audit, there was a resident with an infection. The clinical lead/RN contacted the public health authorities regarding advice. Staff were observed using standard precautions during cares. There were a stock of personal protective equipment and clothing kept in the resident’s room. Staff interviewed confirmed appropriate knowledge of infection control and prevention.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. Interviews with the caregiver and nursing staff confirm their understanding of restraints and enablers. There were no enablers or restraints in use. The clinical lead/RN is the restraint coordinator. Training in restraint and challenging behaviour has been provided.  |

# 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 1.2.3.3The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy. | PA Low | There are policies and procedures that are reviewed at least two-yearly. The manager described this process and the use of external expertise in review of policies as required. However, health and safety policies have not been updated to reflect the most recent changes in health and safety practices. | Health and safety policies do not align with the Health and Safety at Work Act 2015.  | Ensure that health and safety policies are aligned with the current legislative changes.180 days |
| Criterion 1.3.12.1A 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. | PA Moderate | Medication policies align with accepted guidelines. Medications are stored securely. The service uses a blister pack medication management system. Allergies are recorded on all 10 medication charts reviewed. Medication charts have photo identification. Five out of ten signing sheets were completed appropriately.  | (i)There were signing gaps in four out of ten medication charts reviewed. (ii) One medication was charted once a day and medication was taken from the blister pack but it was not signed as administered.  | Ensure that medications are signed as administered. 30 days |
| Criterion 1.3.3.3Each 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 | For the five resident files reviewed, initial assessments were completed within 24 hours of entry and the long-term care plans were developed within 21 days. All resident files reviewed had initial assessments and paper-based risk assessments completed on admission. The GP reviewed the residents within 48 hours of admission. Care plan evaluations were not completed six-monthly. On the day of audit there were 25 residents and interRAI data showed 19 completed assessments. There were 11 residents who are overdue for assessment, ranging from 90 to 593 days overdue. | (i)Five files reviewed evidenced the following: 1) one resident was admitted in 2010 whose first interRAI assessment has yet to be completed; 2) two residents were admitted late 2016 whose initial interRAI assessments have yet to be completed; 3) two files six-monthly interRAI assessments are overdue. The service reports that it has been difficult to complete interRAI assessments due to only one RN who is interRAI competent. Now there is a process in place to access training for the second RN. (ii) In two of five files reviewed, care plan evaluations were not completed six-monthly.  | (i)Ensure all residents have a documented interRAI assessment within 21 days of admission and thereafter at least six-monthly. (ii)Ensure that care plan evaluations are completed at least six-monthly.90 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.

|  |
| --- |
| No data to display |

End of the report.