

Heritage Lifecare Limited - Waiapu House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Waiapu House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 12 September 2017 End date: 12 September 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:	74

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

Waiapu House provides rest home and hospital level care for up to 74 residents. The service is operated by Heritage Lifecare Limited (HLL) and managed by a facility manager. The facility is supported by a senior management team from HLL and a clinical service manager. Residents and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

The audit has resulted in one new area requiring improvement in relation to interRAI assessments not being current and up to date.

There were two areas identified as requiring improvement from the previous audit. One in regards to interRAI training and staff mandatory annual training and competencies not being completed have been effectively closed out.

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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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Open disclosure occurs when any adverse event occurs.

The facility manager is responsible for complaints management. A complaints register is maintained with complaints resolved promptly and effectively.

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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Business and quality and risk management plans include the scope direction, goals, values and mission statement of the organisation. Monitoring of services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identified trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with

corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated as required. Waiapu House Lifecare are currently implementing the HLL policies and procedures.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs 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.		Standards applicable to this service fully attained.
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The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by permanently employed staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

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 building warrant of fitness (expiry 01 March 2018) is publicly displayed at reception.

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.
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The organisation has implemented policies and procedures that support the minimisation of restraint. Two enablers and 10 restraints were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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.
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Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	15	1	0	0	0	0
Criteria	0	38	1	0	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 concerns/complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents and family members on admission to the service and there is complaints information and brochures available in all service areas in the facility.</p> <p>The complaints register reviewed evidenced nine complaints since April 2017. No records were available prior to the changeover of service providers to Heritage Lifecare Limited (HLL). All complaints were documented and completed within the timeframes specified in the Code. Action plans reviewed showed any required follow-up and improvements have been made where possible. All complaints were effectively closed out, signed off and dated appropriately. There have been no complaints to the coroner, police or the Health and Disability Commissioner. The advocacy policy was linked to the complaints management and contact details of the local advocate was available if needed.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their, or their relative`s status and were advised in a timely manner about any incidents or accidents and outcomes of any urgent medical reviews. This was supported in residents` records reviewed. There was also evidence of resident/family input in the care planning process. Staff interviewed understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Policy states that full and frank information of any resident</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>adverse, unplanned or untoward event is given to all relevant parties as needed.</p> <p>Interpreter services are accessible via the DHB and the national interpreter service which is a twenty-four hour service. Staff represent many different nationalities and are pleased to provide interpretation as and when needed for residents for whom English is not their first language.</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>The quality and business plans for 2017 – 2018 for Waiapu House was sighted. Heritage Lifecare Limited reviews the business plan annually. The business plan outlines the purpose, values, scope, direction and goals of the organisation. The documents reviewed described annual and longer term objectives and the associated operational plans.</p> <p>The facility manager provides weekly and monthly reports to HLL support office, the operations manager and the quality team against a range of objectives and KPIs. A sample of reports reviewed showed adequate information is reported to monitor performance and to report any emerging trends, risks and/or issues arising.</p> <p>The organisation chart was displayed in the facility manager`s office and is accessible online and in the quality manual.</p> <p>The service is managed by a facility manager who holds relevant health and postgraduate business qualifications. The facility manager brings experience working internationally to the role. The facility manager has been in this role since the 20 February 2017. The facility manager is suitably skilled and experienced for the role and has responsibilities and accountabilities defined in a job description and individual employment agreement. The facility manager is learning about the sector, regulatory and reporting requirements and is supported by the organisation`s regional operations manager and the quality compliance manager. The clinical services manager has only been in the role for three weeks and is supported by the facility manager.</p> <p>The service holds contracts with the Hawke`s Bay District Health Board (HBDHB). The contracts include mental health (two) residents, long term support chronic health (Nil) residents, respite and day care (no residents at the time of audit), engage ARRC Residential Care Services (GP) and 40 rest home and 32 hospital level residents. Waiapu House had full occupancy of 74 residents on the day of audit.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established,</p>	<p>FA</p>	<p>The organisation has a quality and risk system that reflects the principles of continuous improvement. The quality and risk plan for 2017 – 2018 is developed and implemented for Waiapu House. Quality indicators are clearly documented. The quality and risk system in place includes management of incident and complaints, audit activities, a regular satisfaction survey, monitoring of outcomes, clinical incidents inclusive of infections and any other events that occur.</p> <p>Terms of reference and meeting minutes reviewed confirmed adequate reporting systems and discussion occurs on</p>

<p>documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>quality matters. Regular review and analysis of quality indicators (clinical and non-clinical) occurs and related information is discussed at the staff/quality meetings held monthly. Resident meetings are held two monthly. Staff meeting minutes reviewed included discussion on pressure injuries, restraints, falls, complaints, incidents/events, infections, audit results and activities. Staff reported their involvement in quality and risk activities through audit activities. Relevant corrective actions are developed and implemented as necessary and demonstrated a continuous process of quality improvement is occurring. Resident and family surveys are completed annually. The results of the last survey in February 2017 which were completed under the ownership of the previous service provider were not available. Heritage Lifecare Ltd have scheduled annual surveys for September each year.</p> <p>The policies and procedures reviewed cover all necessary aspects of service provision and contractual agreements are current. The HLL policies and procedures are currently being implemented at Waiapu. The document control system ensures a systematic and regular review process during this transitional phase is occurring. Referencing of relevant sources, approval, distribution and removal of obsolete documents. Staff are updated on new policies or changes to policies through the quality compliance manager.</p> <p>There is a risk register which shows consistent review and upgrading of any risks and risk plans. The facility manager is aware of the Health and Safety at Work Act (2015) requirements and these requirements are addressed in policy. Training for staff was held in August 2017.</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>Staff document any adverse and near miss events on an incident form. A sample of incidents forms reviewed were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Folders are kept at each nurses' station. The hazard identification is completed by the health and safety representative. The clinical services manager enters all information into the electronic system (GOSH). The hard copy records are filed in the individual resident's record. The new system has only been in place for one month. The facility manager reports any incidents or adverse events requiring reporting to the quality compliance manager who is responsible for notifying the correct authority if and when required. Continuous quality improvement related to incidents covers, for example, falls, skin tears, pressure injuries and restraint/enabler use. One improvement has been the introduction of a physiotherapist one day a week and a physio-assistant employed 15 hours a week to carry out any instructions of the physiotherapist for individual residents. Any cares are documented on the resident's care plan.</p>
<p>Standard 1.2.7: Human Resource</p>	<p>PA Negligible</p>	<p>Policies and procedures are in line with good employment practice and relevant legislation, guide human resources management processes. Position descriptions reviewed were current and defined the key tasks and accountabilities</p>

<p>Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>for the various roles. The recruitment process includes referee check, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are systemically maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role and included support from a `buddy` through their initial orientation period. Staff records reviewed showed documentation of completed orientation and a performance appraisal system is in place.</p> <p>Continuing education is planned. The annual education plan for 2017 – 2018 was reviewed. All mandatory training requirements are defined and scheduled to occur over the course of the year. This was a corrective action from the previous audit that has been addressed. Care staff have either completed a recognised education programme or are enrolled to meet the requirements of the provider's agreement with the HBDHB. Education records reviewed demonstrated completion of the required training. An issue has been raised in 1.3.12.3 in relation to ensuring bureau nurses have had the appropriate medication competency training to perform this role. Registered nurse interviewed reported the annual performance appraisal process provides an opportunity to discuss individual training needs. Appraisals were current for staff.</p> <p>The service had five registered nurses who were trained in interRAI. Three registered nurses have recently resigned. Two registered nurses are fully trained and a registered nurse has been employed two days a week commencing the week of the audit, who will solely work on the interRAI assessments. Three are booked in for interRAI training as evidenced through correspondence in the form of an email but no commencement date has been received. This was an area for improvement identified at the previous audit which remains open.</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>Heritage Lifecare Limited has introduced a rationale and process for staffing Waiapu House. The facility and clinical services manager reported this has been a challenge with the new structure and distribution of staff across the facility. The newly implemented roster system rolled over on 21 August 2017. The care staff no longer are responsible for additional non-caring tasks and have to get prior approval for any shift changes. The roster reviewed ensures adequate staff coverage is available on all shifts. A handover occurs between all shifts and this was observed during the audit. The minimum number of staff is provided during the nightshift and consists of one registered nurse across the facility and four care staff. An after-hours on call roster is in place. Staff and families interviewed reported they are still adjusting to the way the staff cover the facility. Families commented that their relatives are well cared for by the staff. The organisation contracts to a bureau for short notice roster/staffing gaps. At least one staff member a shift has a current first aid certificate and there is 24 hour, seven days a week registered nurse coverage.</p>
<p>Standard 1.3.12: Medicine</p>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the</p>

<p>Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All permanent staff who administer medicines are assessed competent to perform the function they manage. One bureau nurse is used regularly and the process for ensuring competency is not applied to the bureau role. On the day of the audit she was administering medications. This was discussed with the clinical services manager and facility who understood, and during the audit observed the RNs practice for medication administration, no issues were identified. The need to obtain evidence of current medication competency for all staff who administer medication was understood following discussion.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review is consistently recorded on the medicine chart by one of 32 GP's supporting residents at the facility. Standing orders are used, were current and comply with guidelines.</p> <p>There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors.</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</p>	<p>FA</p>	<p>The food service is provided on site by qualified kitchen co-ordinator and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen co-ordinator has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p>

<p>service is a component of service delivery.</p>		<p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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 programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy and two activities coordinators.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three-monthly and as part of the formal six-monthly care plan review.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' discussions and meetings with families. Residents interviewed confirmed they find the programme interactive.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds. When necessary, and for unresolved problems, long term</p>

timely manner.		care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness (expires 01 March 2018) is publicly displayed.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality manager. Data is benchmarked externally within the organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The clinical services manager interviewed is the restraint minimisation and safe practice coordinator for Waiapu House. The service is currently changing over to the HLL resident restraint/enabler form and documentation. The restraint minimisation and safe practice policy was reviewed. The restraint minimisation and safe practice register was reviewed and contains all relevant information required. The enablers in use were the least restrictive and were used voluntarily at the request of the residents. There are no rest home level residents using a restraint and/or an enabler. There are two hospital residents using an enabler and 10 residents using restraints. Six residents are using bedrails and four residents 'pelvic briefs'. The process in place ensures the on-going safety and wellbeing of the resident. Restraint is used as a last resort when all alternatives have been explored.

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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)
Criterion 1.2.7.3 The appointment of appropriate service providers to safely meet the needs of consumers.	PA Negligible	Despite a plan in place being developed the clinical services manager and facility discussed the lack of progress with interRAI assessments being performed in a timely manner. Three registered nurses are currently enrolled to complete interRAI training but no date has been confirmed. A registered nurse has been employed two days a week solely for the interRAI programme but has not yet commenced this role.	On the day of the audit the facility manager and the clinical services manager reported they are not able to remain up to date with interRAI assessments due to a lack of staff having completed the required training. Twelve (12) interRAI assessments are overdue (June to August) and two are in draft.	Ensure the plan for additional registered nurses to attend interRAI training is implemented. Continue with tracking and monitoring interRAI assessments as is currently being done. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.