

# Radius Residential Care Limited - Radius Hampton Court

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## 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:

<b>Legal entity:</b>	Radius Residential Care Limited	
<b>Premises audited:</b>	Radius Hampton Court	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 19 January 2018	End date: 19 January 2018
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	41	

# Executive summary of the audit

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## 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

Hampton Court is owned and operated by Radius Residential Care Limited. The service provides rest home and hospital (geriatric and medical) level care for up to 45 residents.

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

On the day of the audit, there were 41 residents. A registered nurse, with experience in aged care management, manages the service. A regional manager and clinical nurse manager support her. Residents, relatives and the GP interviewed spoke positively about the service provided.

One of the two shortfalls identified at their previous certification has been addressed relating to interRAI assessments. Further improvements continue to be required around medication documentation.

There were three further improvements identified at this audit around neurological observations, annual performance appraisals and care plan interventions.

## 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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Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Complaints and concerns have been managed and a complaints register is maintained.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Services are planned, coordinated, and are appropriate to the needs of the residents. Goals are documented for the service with evidence of regular reviews. A quality and risk management programme is embedded. Corrective actions are implemented and evaluated where opportunities for improvements are identified. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. Ongoing education and training is in place, which includes in-service education and competency assessments. Registered nursing cover is provided 24 hours a day, seven days a week. Residents and families report that staffing levels are adequate to meet the needs of the residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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Care plans are developed by the registered nurses, they also have responsibility for maintaining and reviewing care plans. Care plans reviewed were individually developed with the resident, and family/whānau involvement is included where appropriate and evaluated six-monthly or more frequently when clinically indicated. The medication management system in place follows appropriate storage practices and each resident is reviewed at least three-monthly by their general practitioner. A range of individual and group activities is available. All meals are prepared on-site. There is a seasonal menu in place, which is reviewed by a dietitian. Residents' food preferences are accommodated and the residents and relatives report satisfaction with the food service.

## 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 displays a current 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.
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Staff receive training around restraint minimisation and the management of challenging behaviour. The service has appropriate procedures and documents for the safe assessment, planning, monitoring and review of restraint and enablers. There are currently no residents with enablers or restraint. Staff are trained in restraint minimisation.

## 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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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information is used to identify opportunities for improvements.

## 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)
<b>Standards</b>	0	12	0	2	2	0	0
<b>Criteria</b>	0	35	0	2	2	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
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. Complaints forms are available. Information about complaints is provided on admission. Interviews with all residents and relatives confirmed their understanding of the complaints process. Staff interviewed were able to describe the process around reporting complaints. A complaints' register includes written and verbal complaints, dates and actions taken. Three complaints have been made since the last audit. All complaints received have been documented as resolved with appropriate corrective actions implemented.
Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective	FA	Four residents (two rest home and two hospital) interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Ten incident reports reviewed evidenced recording of family notification. Four relatives (one rest home and three hospital) interviewed, confirmed they are notified of any changes in their family member's health status. Three monthly resident meetings provide a forum for residents to discuss issues or concerns. Families are encouraged to visit. The facility has an interpreter policy to guide staff in accessing interpreter services.

communication.		
<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>	FA	<p>Hampton Court is a Radius aged care facility located in Napier. The facility is certified to provide care for up to 45 residents requiring hospital and rest home level care. There are 15 rest home beds and 30 dual-purpose beds. On the day of the audit, there were 41 residents in total, 20 residents receiving rest home level care and 21 receiving hospital level care including one resident on respite. All other residents were on the age related residential care (ARRC) agreement.</p> <p>The Radius strategic plan describes the vision, values and objectives of Radius aged care facilities. The service organisation philosophy and strategic plan reflect a person/family centred approach. An annual 2017/2018 business plan for Hampton Court describes specific and measurable goals that are reviewed each month. The business plan is updated annually.</p> <p>The facility manager is a registered nurse (RN) with many years' experience in aged care. She has been in the role since July 2017 and has worked at Radius for three and a half years. She supported by a regional manager and clinical nurse manager. The regional manager was present on the day of the audit as she was training another regional manager through her induction. The clinical nurse manager has been in the position since August 2017 and has many years' experience in the aged care industry.</p> <p>The facility manager has maintained at least 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 established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>There is an organisational business plan that includes quality goals and risk management plans for Hampton Court. Quality and risk performance is reported across facility meetings and to the regional manager. The facility manager advised that she is responsible for providing oversight of the quality programme. There is a monthly quality/health and safety, and bi-monthly staff meeting where all quality data and indicators are discussed. Minutes of these meetings are made available to all staff. Resident meetings are three monthly. Annual resident/relative satisfaction surveys are completed with results communicated to residents and staff. The overall service result for the resident/relative satisfaction survey completed in July 2017 was at 100%.</p> <p>The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The clinical managers group, with input from facility staff, reviews the service's policies at national level every two years. Clinical guidelines are in place to assist care staff. The quality monitoring programme is designed to monitor contractual and standards compliance and the quality of service delivery in the facility and across the organisation. Data is collected in relation to a variety of quality activities and an internal audit schedule has been completed. Areas of non-compliance identified through quality activities are actioned for improvement. Corrective actions are evaluated and signed off when</p>

		<p>completed.</p> <p>Health and safety policies are implemented and monitored by the health and safety committee. The health and safety representative (maintenance person) interviewed confirmed their understanding of health and safety processes. He has completed the specific health and safety training requirements. Risk management, hazard control and emergency policies and procedures are in place. There are procedures to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Radius has achieved tertiary level ACC Workplace Safety Management Practice. Falls prevention strategies are in place including intentional rounding, sensor mats, post falls reviews and individual interventions.</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>	PA Low	<p>There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Incidents are included in the Radius key performance indicators (KPI). There is a discussion of incidents/accidents at monthly staff and quality/health and safety meetings including actions to minimise recurrence. Ten accident/incident forms were reviewed. Each event involving a resident, reflected a clinical assessment and follow-up by a RN. However not all neurological observations were completed for resident falls that resulted in a potential head injury. Data collected on incident/accident forms are linked to the quality management system. The management team are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been no requirements to complete any section 31 notifications since the last audit.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files (one RN, two healthcare assistants (HCA), one maintenance person and one activities coordinator) reviewed, included a recruitment process, which comprised reference checking, signed employment contracts and job descriptions, police checks, and completed orientation programmes. However, there was no documented evidence of an up-to-date annual performance appraisal completed in five of five staff files reviewed. A register of registered nursing staff and other health practitioner practising certificates is maintained. The orientation programme provides new staff with relevant information for safe work practice.</p> <p>There is an annual education and training plan in place that exceeds eight hours annually. There is an attendance register for each training session and an individual staff member record of training. Registered nurses are supported to maintain their professional competency. There has been recent turnover of RN positions which has resulted in currently only one of the eight RNs at Hampton Court being interRAI trained. The facility manager</p>

		and clinical nurse manager are also interRAI trained. All interRAI assessments reviewed were regular and timely, although interRAI outcomes were not always reflected into care plans (link 1.3.6.1). This previous finding around timeframes has now been addressed.
<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>	FA	<p>A policy is in place for determining staffing levels and skills mix for safe service delivery. Rosters implement the staffing rationale. The facility manager and clinical nurse manager both work full time from Monday to Friday and share the on-call 24/7 duties. There is a minimum of one RN and two HCAs on-site at any time. There is one RN on duty in the morning shift and afternoon shift, and on the night shift. The RNs are supported by six HCAs (three long and three short-shifts) on the morning shift, five HCAs (two long and three short-shift) on the afternoon shift and two HCAs on the night shift. Staff working on the day of the audit were visible and were attending to call bells in a timely manner. Staff interviewed stated that overall, the staffing levels are satisfactory and that the managers provide good support. Residents and family members interviewed report there are sufficient staff numbers.</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>	PA Moderate	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. All residents have individual medication orders with photo identification and allergy status documented. The service uses a four-weekly packaged system for tablets, and other medicines are pharmacy packaged. All medicines are stored securely when not in use. A verification check is completed by the RN against the resident's medicine order when new medicines are supplied from the pharmacy. The medication room was clean and organised and short-life medications (ie, eye drops and ointments) are dated once opened.</p> <p>Education on medication management has occurred with competencies conducted for the RN and senior HCAs with medication administration responsibilities. Ten medication charts reviewed identified that the GP had seen the resident three-monthly. The paper-based medication orders do not always include indications for use of 'as needed' medicines, not all administration charts had been signed on administration and GPs had not always signed for medication. An RN was observed administering medications and followed correct procedures. No residents self-administer medicines; a process is documented should residents wish to self-administer.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are</p>	FA	<p>There is a fully functional kitchen and all food is cooked on-site. A food services manual is in place to guide staff. A resident nutritional profile is developed for each resident on admission, and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the kitchen manager works closely with the RNs on duty. The kitchen staff have completed food safety training. The kitchen manager and cooks follow a rotating seasonal menu, which has been reviewed by a dietitian. The temperatures of refrigerators, freezers and cooked foods are</p>

<p>met where this service is a component of service delivery.</p>		<p>monitored and recorded. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were very happy with the quality and variety of food served.</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>PA Moderate</p>	<p>Service delivery is guided by the resident's plan of care, handovers and care charts. The software assessment process informs the development of the care plan and interRAI outcomes are added. InterRAI outcomes were not always reflected into care plans. Care plans sampled were goal orientated and reviewed at six monthly intervals (for long-term residents). The staff interviewed stated that they have sufficient equipment and supplies to provide care. The respite resident had an up-to-date care plan in place and one resident with oxygen had this documented, which included care needs associated with oxygen use.</p> <p>Three residents with wounds were reviewed for this audit. There were no residents with a pressure injury. Assessments, management plans and documented reviews were in place for all wounds. Specialist nursing advice is available from the DHB as needed. A physiotherapist is available two days during the week to assist with mobility assessments and the exercise programme. Monitoring records sighted (weights, food and fluids and turning charts) were consistently completed occurring to set timeframes, however pain assessments were not always documented, and neurological observations were not always documented according to policy (link 1.2.4.3). Residents and family members interviewed confirmed their satisfaction with care delivery.</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 service employs one activities person who provides an activity programme Monday to Friday. The activities person is responsible for the planning and delivery of the individual and group activities programme with assistance from staff. Activities assessments and plans are integrated into the care planning software. All resident files sampled have a recent activity plan within the care plan and this is evaluated at least six monthly when the care plan is evaluated. Residents are free to choose to participate in the group activities programme, or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Residents and families interviewed commented positively on the activity programme.</p> <p>The programme is developed with input, including feedback from residents. Regular outings occur in the new van purchased by the service. There is engagement with the local community, such as inter-home bowls matches. Activity plans include art deco week, long lunches, exercises and entertainment. Individual activities are provided in residents' rooms or wherever applicable. On the day of the audit, residents were observed being actively involved with a variety of activities. The group activities programme is developed monthly, and a copy of the programme is available in the lounge, on noticeboards and in each resident room. The group programme includes residents being involved within the community with social clubs, churches and schools.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Residents are reassessed using the interRAI and computer-based assessments. Long-term care plans are then evaluated and updated. There was documented evidence that care plan evaluations were current in resident files sampled. The files sampled documented that the GP had reviewed residents three-monthly (for those that had been at the service longer than three months) or when requested, if issues arise or their health status changes. The RNs interviewed explained the communication process with the GP. Short-term care plans were evident for the care and treatment of residents and had been evaluated and closed or transferred to the long-term care plan if required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is prominently displayed, expiring 1 July 2018.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection surveillance is an integral part of the infection control programme and is described in the Radius infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. An individual resident infection form is completed, which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually and provided to Radius head office. Infections are part of the key performance indicators. Outcomes and actions are discussed at quality/health and safety meetings and staff meetings. If there is an emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the facility manager. There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint</p>	FA	<p>Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. Restraint minimisation policies and procedures are in place and include definitions, processes, and use of restraints and enablers. There are no residents with restraint or enablers at Hampton Court. The service is committed to restraint minimisation and safe practice, as evidenced in the restraint policy and interviews with the facility manager, clinical nurse manger and HCAs. Staff are trained in restraint</p>

is actively minimised.		minimisation.
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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Ten accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a RN. However, not all neurological observations were completed for resident falls that resulted in a potential head injury.	Ten accident/incident forms were reviewed in total. Seven accident/incident forms reviewed were for unwitnessed falls where the resident could have potentially hit their head. In six out of the seven accident/incident forms reviewed, the neurological observations were either not completed or were not completed to the required timeframes (as per the Radius policy).	<p>Ensure that neurological observations are undertaken for any resident fall with a potential head injury and are fully completed as per the policy.</p> <p>90 days</p>
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and</p>	PA Low	Human resources policies include recruitment, selection, orientation and staff training and development. Five staff files (one RN, two HCAs, one maintenance person and one activities coordinator) were reviewed. There was no documented evidence of an up-to-date	There was no documented evidence of an up-to-date annual performance appraisal completed in five of five staff files reviewed.	<p>Ensure that all staff performance appraisals are completed annually.</p> <p>90 days</p>

scope of practice for service providers.		annual performance appraisal completed in five of five staff files reviewed.		
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Moderate	All residents have a paper based medication chart and associated signing forms. Warfarin was correctly prescribed and administered according to INR results. Ten medication charts were reviewed. They all document at least a three-monthly GP review and were clear and easy to read. Not all documentation and signing were in place. This is a continued finding from the previous audit.	(i) Indications for use for 'as needed' medications were not documented on four of ten medication charts reviewed. (ii) There were signing gaps for staff administration for four of ten medication charts. (iii) The GP had not signed for one medication on one medication chart.	(i) Ensure that all 'as needed' medication documents indications for use. (ii) Ensure that staff sign for medications on administration. (iii) Ensure that all medication prescriptions are signed by the prescriber.  30 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Moderate	The service has implemented a new software-based care plan and progress notes process. The service is aware that this process may cause documentation issues during this transition phase and has implemented a plan to ensure that resident care is provided. This includes in-depth handovers, work logs for each resident (tasks needed) and summary of care sheets. RNs and senior staff advise they are being extra vigilant to ensure care needs are met.	(i) Two hospital and two rest home level residents did not have all interRAI outcomes reflected in to their care plans.  (ii) Pain assessments were not documented for a hospital resident who required strong analgesia.  (iii) One resident who had bruises recorded did not have this documented as followed-up by an RN.	(i) Ensure that the interRAI assessment process is reflected into the care plans. (ii) Ensure that pain assessment is documented as completed for residents with identified pain. (iii) Ensure that issues noted by HCAs are followed up, assessed and documented by the RNs.  30 days

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

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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
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End of the report.