Experion Care NZ Limited - Greendale Residential Care

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 Q-Audit 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:	Experion Care NZ Limited
Premises audited:	Greendale Residential Care
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 18 May 2018 End date: 18 May 2018

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 22

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Greendale Residential Care is an aged care facility owned by Experion Care NZ Limited. The service provides rest home level care and holds mental health; respite; and LTS-CHC contracts. On the day of the audit there were 22 residents. There has been a change in the management team since the last audit. A new clinical manager has been appointed

This unannounced surveillance audit was conducted against a subset of Health and Disability Services Standards and the service contract the district health board (DHB). The audit process included review of policies and procedures, review of residents and staff files, observations and interviews with residents, families, management, staff and a general practitioner.

The four previous areas requiring improvement have been addressed, however there are four areas for improvement identified during this audit relating to the mission and vision of the organisation, policies and procedures, interRAI assessments and menu reviews.

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.

Communication systems are appropriate to the needs of the residents. Sufficient information is made available. Interpreter services can be accessed if required. Interviews with residents and family/whanau confirmed open communication opportunities with management and staff.

Staff demonstrated knowledge and understanding of the Health and Disability Commissioners Code of Health and Disability Services Consumers' Rights (the Code). Residents interviewed confirmed that their independence, wishes, and rights are respected and that they can raise areas of concern with all staff members and have actions taken.

The complaints process is accessible. Records of complaints sampled confirmed appropriate and timely response. All complaints are followed up by the nurse manager (NM). A complaints register is maintained. Residents interviewed stated that they are comfortable raising complaints with the new clinical manager. All complaints are recorded including verbal complaints. It was reported that no complaints to external bodies have been lodged since the last audit.

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.

The organisation is governed by an owner who owns three residential rest homes in New Zealand. The day to day running of the facility is undertaken by the clinical manager (CM) who is supported by the nurse manager (NM). The NM has the responsibility of running two homes for Experion Care NZ Limited in Napier. Organisational performance is closely monitored.

There is a documented quality and risk management system. Quality data is used to improve the services. Policies and procedures are current. All adverse events are documented, investigated and closed in a timely manner.

The human resource process ensure suitably qualified staff are on site over the 24-hour period. Competencies are maintained and there are sufficient staff 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.

The nurse manager and the clinical manager are responsible for care plan development with input obtained from residents, staff and family/whanau members. Assessments and care plans are documented and evaluated.

Planned activities are appropriate to the residents' assessed needs and abilities. In interviews, residents and family/whanau expressed satisfaction with the activities programme in place.

Medications are managed and administered in line with the required legislation guidelines. Medications are monitored and reviewed by the general practitioner (GP) as required. The service uses a pre-packaged medication system in prescribing, dispensing and administration of medications. Staff involved in medication administration are assessed as competent.

Nutritional needs are provided in line with nutritional guidelines and residents with special dietary needs are catered for.

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 have been no changes to the facility since the last audit. There is a current building warrant of fitness and approved fire evacuation plan.

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.

There are clear and comprehensive documented policies and guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated understanding of restraint and enabler use and receive ongoing restraint education.

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.

There is a monthly surveillance programme, where infections are collated, analysed and trended with previous data. Where trends are identified, actions are implemented to reduce infections. The infection surveillance results are reported at the staff meetings.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	14	1	2	1	0	0
Criteria	0	40	1	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.

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	There is a detailed complaints process set out in policy. The process provides details of how to make a complaint, how to access advocacy services or make a complaint to the Health and Disability Commission (HDC) and refers to Right 10 of the Code. The complaints process is also outlined in the residents' handbook and in the admission agreement. Complaint forms are available at the front desk along with information on advocacy services available. In the entrance area are posters of the Code are displayed in both English and Maori. A complaints register is maintained. This provides evidence that complaints are dealt with in the time frames set out in policy. The nurse manager (NM) is responsible for the complaints and responding in writing. Any findings are part of feedback both at the staff meetings and the residents' meetings using information to form part of the quality process, meeting minutes sampled confirmed this. Staff cover the complaints process in orientation and through internal training. Training records sampled confirmed this. In the previous audit residents stated that they did not feel they could make complaint and at least one verbal complaint had not been addressed. During this audit evidence of verbal complaints being recorded was evident in the complaints register. The NM has provided additional training to staff and informed residents that complaints are used to improve the service. Review of staff and residents' meeting minutes confirmed this has occurred. Residents interviewed stated that they feel there is an open-door policy and are comfortable to raise their concerns. Residents stated in interview that they raise issues at their meetings and they are dealt with.

		It was reported that there have been no investigations by HDC, Ministry of Health (MoH), the Accident Compensation Commission (ACC) police or coroner since the last audit.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Processes implemented by management and staff ensure that residence's right to privacy and dignity are recognised and respected at all times. Services are provided in a manner that maximises each resident's independence Related policies define abuse and neglect, reference legislation, and provide instructions on dealing with abuse and neglect. Staff receive education regarding abuse and neglect. Staff interviewed verbalised the actions of everyday practice to ensure residents are treated with respect and privacy whilst encouraging independence. All family members interviewed were positive with the high level of respect afforded to the residents by staff and management. Residents individual wishes were evidenced in care planning sighted. The previous area requiring an improvement has been sufficiently addressed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	The open disclosure policy is current, sets out practice guidelines and has relevant references. Review of the incident and accident register demonstrated that open disclosure to residents and/or their families occurs within the time frames set out in policy. Staff files sampled confirmed that each resident has family/whanau contact information. Each contact with family/whanau is documented in the residents' files and on the incident / accident sheet. Families interviewed confirmed that they are contacted and that they are happy with the amount of contact. Residents have bi monthly meetings, minutes sampled demonstrated that information is shared. Interpreter services are available. Staff are informed of the service through the policy at orientation. Residents and families are informed of the interpreter services in the resident's information provided. No resident has required an interpreter since the home was purchased. Staff confirmed in interviews they would contact management if an interpreter was required. The managers confirmed that they have access to the interpreter service through the Hawkes Bay District Health Board (HBDHB). In interviews residents and family/whanau members stated they feel comfortable discussing any matter with staff or management.
Standard 1.2.1: Governance The governing body	PA Negligible	Greendale Residential Care is one of three rest homes in the Experion Care NZ Ltd company. The rest home was purchased in March 2016 and the current NM is responsible for the overall running of the home and has been in the role since January 2017. The clinical manager (CM) oversees the day to day running of the home with support from the NM who also manages one of the other homes in the group. The CM has been in the role since March 2017.

of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		The NM and CM are both registered nurses. They work closely together and provide 24/7 nurse cover. The NM reports to the owner monthly using comprehensive quality management report and more frequently if needed. Both RNs have detailed position descriptions, current practicing certificates and attend the required training. The organisation has vision and mission statements identified in the quality manual, the business plan, in the residents' handbook and on the wall, however an improvement is required to ensure these are consistently documented. Residents and their families are made aware of the vision and mission in the handbook. The strategic plan is current and reviewed annually to ensure the services offered meet the needs of the residents and monitored through the monthly report to the owner. The organisation is certified to provide rest home care. Additional contracts held with the district health board include the provision of mental health, long-term support and respite. The home has 24 beds and on the day of the audit there were 22 residents residing in the facility: 18 were rest home care, one was accessing respite services through DHB respite contract, one accessing long term support under LTS-CHC contract and two residents under the mental health contract. One of the mental health residents and the resident on LTS-CHC contract were both less than 65 years of age.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	There is a documented business quality and risk management plan dated 2018. The plan identifies risks, responsibilities and controls. Quality and risk is integrated into the business plan and other organisational systems including: incident/accident process; complaints system: infection control and the health and safety system. Documentation in the quality and risk management system are reviewed bi -annually. Staff interviewed confirmed that they understand the quality system and that they are provided with the comprehensive monthly quality management report that is sent to the owner. Other less formal communication is undertaken by the NM and the owner via email and telephone. The internal audit system was viewed and results from 2017 and first quarter of 2018 were sited. The information from internal audits is reported in the monthly quality management report. Service shortfalls are promptly identified and monitored until the required threshold is met. Areas for improvement that are identified are either managed through the staff, resident or manager meeting system where the corrective action is documented in the minutes and signed off at the next meeting or transferred to a corrective action form. The data from internal audits is bench marked against the indicator used in each facility in the group. Policies and procedures are available to staff; however, an improvement is required to ensure that all policies and procedures are individualised to the organisation. All documents viewed had been reviewed as required. The document control process is clear and integrated into the quality system. Evidence of updating documents was viewed. Staff sign when they have read a new document. Obsolete documents are removed from circulation. Key components for service delivery are linked to the quality system and are standing agenda items in the monthly

		meetings. In interviews staff, family/whanau and residents confirmed that they are comfortable raising any issues, including newly identified actual and potential hazards with the management that issues are addressed.
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	There is a system for reporting and managing adverse events. Staff record adverse, unplanned or untoward events on incident / accident form. The NM collects information required and analyses the data and this data is reported at the monthly meetings and compared to other months data. Information is used to feed into the quality system and improvements made. Management are aware of the statutory requirements for reporting. Three reports have been made since the last audit; one was for an outbreak of norovirus, the Ministry of Health (MoH) and the other two for residents leaving the premises. Reports and two responses from the MoH were sampled. Additional accidents/ incidents were sampled from the register. These confirmed that the events are well managed, families informed, and events closed off in a timely manner. Staff interviewed confirmed their understanding of the process and the need to report. Residents and families confirmed in interview that the process was understood and easy to use.
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	Human resource policies and procedures are in place and support good practice. There is a defined recruitment process which validates professional qualifications and police checking. The CM is responsible for undertaking the recruitment processes and the NM signs off appointments. Detailed position descriptions are outlined for each role. All staff employed since Greendale was brought by Experion Care Limited have received orientation. This includes all essential components of service delivery including emergency management. Staff files reviewed confirmed this. The in-service training programme includes all mandatory education required. Staff records sampled confirmed education requirements have been met. The organisation requires a broad range of competencies to be completed this includes but not limited to: medication; restraint (including challenging behaviour); first aid; mental health; abuse and neglect. The staff training plan is developed annually and incorporates information gathered from the previous year's quality data. The training plan from 2017 was sampled. Annual practicing certificates for the RN's were sighted. The interRAI assessments are being managed by the NM for both homes. The CM has completed the interRAI training and is currently awaiting sign off (refer standard 1.3.3). Care givers are working toward their career force levels. Staff performance is monitored. This includes annual performance appraisals. Staff records sampled included

		recruitment, orientation, training, competencies and appraisals records. In interview staff confirmed completion of orientation and attendance at required training. The residents, families and general practitioner (GP) interviewed all reported satisfaction with the knowledge and skills of staff.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a process that defines staffing levels. This meets the requirements outlined in the organisations contracts with the local district health board. There is a registered nurse (RN) on morning shift Monday to Thursday. The 24 hour on call RN cover is provided by the CM and the NM. If further RN cover is needed the RN from the other home is available to cover. Rosters sampled evidenced that there are two care givers (CG) on duty in the morning shift; two CG on afternoon shift and one GC on night shift. Each shift has a CG with a current first aid certificate. All sick and annual leave is covered using existing staff, staff from the other facility or on rare occasions by agency. There are sufficient numbers of kitchen, housekeeping and activities staff. Observations during the audit confirmed that residents' needs were met in a timely manner. Family/whanau and GP interviewed confirmed that staff were available to meet their needs as 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.	FA	All medication charts sampled confirmed that they are reviewed every three months or as required and discontinued medication are signed and dated by the GP. Allergies are documented, identification photos are present. Medication charts are legibly written. Medication and medication charts are stored safely and securely. Medication reconciliation is conducted by the CM or NM when the resident is transferred back to service. The service uses pharmacy pre-packed packs that are checked by the CM or NM on delivery. The controlled drug register is current and correct. Weekly and six-monthly stock takes are conducted, and all medications are stored appropriately. There were no residents self-administering medication at the time of the audit. There is a policy and procedure for self-administration of medication if required. An annual medication competency is completed for all staff administering medications and medication training records were sighted. The medicines management system complies with current legislation, protocols and guidelines.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	PA Low	Meal services are prepared on site and served in the allocated dining room. There is a four-weekly rotating winter and summer menu in place. The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		cleaning is conducted. The residents and family/whanau interviewed acknowledged satisfaction with the food service. Residents are free to express their concerns about meals during residents' meetings and any changes are considered. Minutes of the meetings were sighted. An improvement is required with regard to menu reviews.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	The documented interventions in short term support needs care plans and resident lifestyle care plans are sufficient to address the residents' assessed needs and desired goals/outcomes. Significant changes are reported in a timely manner and prescribed orders carried out satisfactorily as confirmed by the GP. Progress notes are completed on every shift. Adequate clinical supplies were observed, and the staff confirmed they have access to enough supplies. Residents and family/whanau members interviewed reported satisfaction with the care and support they are receiving.
Standard 1.3.7: Planned Activities 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.	FA	Activities are appropriate to the needs, age and culture of the residents. The activities coordinator develops an activity planner and daily/weekly activities are posted on the notice boards distributed to all residents. Residents' files have a documented activity plan that reflects the residents' preferred activities of choice. Over the course of the audit residents were observed being actively involved in a variety of activities and residents interviewed expressed satisfaction with the activities in place. Individualised activity plans are reviewed six monthly or when there is any significant change in participation and this is completed in consultation with the NM or CM. The activities vary from scrabble, bingo, music, van trips, exercises/walking and church services. The activities coordinator reported that they have group activities and engage in one on one activities with some residents. Activities are modified to varying abilities and cognitive impairment. The residents' daily attendance record was sighted.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Residents' lifestyle care plans and activity plans are evaluated at least six monthly and updated when there are any changes. Some InterRAI assessments were not reviewed within the required time frames refer to 1.3.3.Family/whanau and staff input is sought in all areas of care. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term support needs care plans are developed when needed and signed and closed out when the short-term problem has resolved.

Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There is a current building warrant of fitness. There have been no changes to the facility since the last audit.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved fire evacuation plan. Evacuation drills are conducted as required.
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 the size and complexity of the organisation. There are standardised definitions for the identification of infections. The infection prevention and control coordinator reviews all reported infections, and these are documented. 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 through regular staff meetings and at staff handovers. The analysis is also tabled at the quality meetings. Data is benchmarked externally with other aged care providers.
Standard 2.1.1: Restraint minimisation	FA	The restraint minimisation policy provides consistent definitions for restraints and enablers. No residents were restrained or using enablers on the day of the audit at Greendale Residential Care. All staff receive education regarding restraint minimisation and de-escalation techniques. Staff interviewed are aware of the difference

Services demonstrate that the use of restraint is actively minimised.		between a restraint and an enabler.

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 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	PA Negligible	The purpose, scope, direction and goals of the organisation and documented. These documents were displayed and communicated, however these statements differed in the four documents sampled.	The vision; philosophy and mission statements are not clear due to the duplication of documents.	Clearly identify the organisations purpose, values, scope, direction and goals. 90 days
Criterion 1.2.3.4 There is a document control	PA Low	Policies and procedures are developed by an external consultant. All policies and procedures sampled met current compliance requirements and best practice. There is a system for ensuring	Not all policies and procedures had been	Ensure that all documents in

system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.		policies and procedures are current. Staff confirmed that have access to the required documents when needed. Policies and procedures were sampled during the audit. Some documents sighted had the name of another facility on them and had not been individualised to the organisation.	individualised to the organisation.	the home are relative to the home. 90 days
Criterion 1.3.13.1 Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.	PA Low	The menu was reviewed in 16 February 2016 and still awaits implementation of a new Food Control Plan (FCP). The residents have a dietary profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Meals are served warm in sizeable potions required by residents and any alternatives are offered as required.	The menu has not been reviewed by the registered dietitian in line with recognised nutritional guidelines and the organisation's policy.	Provide evidence that the menu has been reviewed by a registered dietitian. 180 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Files reviewed identified that nursing care assessments and residents' lifestyle care plans are completed within the required time frames. InterRAI assessments are completed within three weeks of admission and care plans are reviewed every six months or when there is any significant change. Some InterRAI assessments were not reviewed within the required time frames that safely meet the needs of the consumer. There is only one staff member (the nurse manager) who was trained in interRAI.	More than 50% of the interRAI assessments had not been reviewed within the required timeframe.	Provide evidence that interRAI assessments are reviewed within the required timeframes. 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.