Golden Pond Private Hospital Limited - Golden Pond Private Hospital

Introduction

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

The audit has been conducted by 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:	Golden Pond Private Hospital Limited
Premises audited:	Golden Pond Private Hospital
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 October 2019 End date: 30 October 2019
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:	59

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

Golden Pond Private Hospital provides rest home and hospital level care for up to 61 residents. The service is operated by the owner/director and managed by a nurse manager and a clinical manager. Residents, staff and family 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 Bay of Plenty District Health Board (BOPDHB). The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

This audit has resulted in the four areas requiring improvement from the previous audit relating to record management, medication management, the food service and an equipment issue being effectively addressed. One new area requiring improvement in relation to interRAI assessments was identified.

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.

Management and staff communicate in an open manner and residents and family members are kept up to date. Residents have access to interpreter services if required. Open disclosure was evident in event records reviewed.

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.		Standards applicable to this service fully attained.

Business and quality and risk management plans include the scope, direction, goals, values and philosophy statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. The quality and risk management system includes collection and analysis of quality improvement data, identifies any trends and leads to quality 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. Policies and procedures support service delivery and were current and reviewed regularly.

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 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.		Some standards applicable to this service partially attained and of low risk.

Residents receive services in a competent and timely manner. The registered nurses (RNs) are responsible for completing nursing assessments, care plans and evaluations. Interventions are adequate to meet the residents' assessed needs.

The planned activities provided are appropriate to meet the needs, age, culture, and setting of the service. The activities reflected ordinary patterns of life and included involvement of other representatives and other community groups.

Golden Pond Private Hospital uses a pre-packaged medication system and e-prescribing system. Medication is administered by staff with current medication administration competencies. Medication reviews are completed by the general practitioners (GPs) in a timely manner.

All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. There was a current food safety plan approved by the Ministry of Primary Industries.

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.

The service has a current building warrant of fitness which is displayed.

Restraint minimisation and safe practice

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

The organisation has implemented policies and procedures that support the minimisation of restraint. Six enablers and seven restraints were in use at the time of the audit. Use of enablers was 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.

The infection control surveillance programme is suitable to the size and scope of the service. Infection rates and antibiotic use are monitored. Data on infections is collated, analysed and trends identified and acted upon where required. There has been no infection outbreak since the last audit.

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	16	0	1	0	0	0
Criteria	0	39	0	1	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
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The concerns/complaints management form and policy were reviewed in February 2019. The documentation meets the requirements of Right 10 of the Code of Health and Disability Services Consumers Rights (the Code). Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. The complaints register reviewed showed that 15 complaints have been received since February 2019 and all actions are taken through to an agreed resolution. Any resolutions are documented and completed within the required timeframes. Action plans showed follow-up and improvements have been made where possible. Two recent complaints have not been closed out. There was one complaint that was recently reported to the DHB and to the nurse manager. Appropriate responses were provided and there has been no correspondence since the 30 August 2019 recorded. The nurse manager is responsible for all complaints. No other external complaints have been received.
Standard 1.1.9: Communication Service providers communicate effectively	FA	Reviewed records in residents' files evidenced that information was provided to residents and family where required. Interviewed residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Interviewed staff understood the principles of open disclosure. Records

with consumers and provide an environment conducive to effective communication.		of adverse events, and progress notes confirmed that family were contacted. Staff knew how to access interpreter services, although reported this was rarely required due to all residents able to speak English, staff able to provide interpretation as and when needed and the use of family members for those with communication difficulties. On the day of the audit, staff were observed communicating with residents in a respectful manner.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business plan is reviewed annually and outlines the purpose, values, scope, direction and goals of the organisation. The philosophy, mission statement and values are documented in the business plan, the service agreement and other documents. A sample of monthly reports to the owner showed adequate information is gathered to monitor performance including any trends, financial performance, emerging risks and/or any issues. The service is managed by the nurse manager who holds relevant qualifications and has been in this role for 21 years. Responsibilities and accountabilities are defined in a job description and individual employment agreements reviewed. The nurse manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through maintaining and meeting the registered nurse annual practising certificate requirements and by attending any management education provided at the Bay of Plenty district health board (BOPDHB) at Whakatane Hospital. The nurse manager is supported by the clinical nurse who has worked in aged care and palliative care for twenty-seven years. The service holds contracts with BOPDHB for palliative care, rest home, respite, hospital level care, long term chronic health and under 65 years (YPD). On the day of audit 59 residents were receiving services under the contracts with four rest home level care residents, 52 hospital level care residents including four LTCH all of whom are under 65 years of age. In addition there are two palliative care residents and one resident was under the accident corporation commission (ACC).
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	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes for example the management of incidents and complaints, internal audit activities, a regular resident satisfaction survey, monitoring of outcomes, clinical incidents including infection control and restraint minimisation. Meeting minutes reviewed confirmed the review and analysis of quality indicators and that related information is reported and discussed at the management quality and risk team meeting and staff meetings. Staff reported their involvement in quality and risk management activities through, for example, the internal audit schedule sighted and minutes of all meetings which were sighted. Staff reported their involvement in infection prevention and control meetings. Relevant corrective actions were developed and implemented to address any shortfalls.

quality improvement principles.		Resident and family satisfaction surveys are completed annually. The most recent survey showed that the families are satisfied with the care and management of residents and family members are responded to in a timely manner. Policies reviewed covered all necessary aspects of all service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The documents control system ensures a systematic and regular review process, referencing or relevant sources, approval, distribution and/or removal of obsolete documents. The nurse manager described the processes for the identification, monitoring, review and reporting of risks and development of any mitigation strategies. The hazard audit was completed 22 July 2019. The environment is checked monthly and an annual report was presented to the owner/director February 2019.The nurse manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
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	Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed, and actions followed up in a timely manner. The nurse manager explained and demonstrated a new system which has been implemented two months ago using the interRAI system for reviewing wounds, pressure injuries and skin tears. Benchmarking occurs monthly with three other aged residential care services and the graphs were available and reviewed. The information provided covered total staff incidents, medication errors, near misses, abuse whether verbal or physical, 'wandering', pressure injuries (stage 2 and above), fractures, skin tears and falls. The adverse events are reported to the director and outcomes fed back to staff at the staff meetings and at handover between shifts. The nurse manager described essential notification reporting requirements, including for pressure injuries. The nurse manager was fully informed about what events have to be reported and understands the Health and Disability (Safety) Act 2001 Section 31 reporting guidelines which were sighted and available to guide staff. Two section 31 notifications have been completed since the previous audit; one in relation to registered nurse coverage and one in relation to a medication misadventure. The later was also reported to the New Zealand Police.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in	FA	Human resource management policies and processes are based on good employment practice and relevant legislation. The nurse manager is responsible for employment and staff management. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs) where required for all health professionals. A sample of records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.

accordance with good employment practice and meet the requirements of legislation.		Staff orientation includes all necessary components relevant to the role. Job descriptions were reviewed. Staff interviewed reported that the orientation process prepared them well for their role. Staff records evidenced documentation of completed orientation and performance appraisals are completed annually. The nurse manger has an implemented system in place for managing this aspect of human resource management. Continuing education is planned with annual mandatory requirements being met and two yearly education undertaken to meet the obligations with the organisation's contract with the DHB. Sixteen staff have completed first aid courses and have current first aid certificates. This training is monitored and refresher courses are completed two yearly. All registered nurses, one enrolled nurse and two team leaders (senior caregivers) have all completed medication competencies. The night staff caregivers are competent 'medication checkers'. Care staff have either completed or commenced a New Zealand Qualification Authority education programme with nine (9) level 1, eight (8) level 2, fifteen (15) level 3, eleven (11) level 4a and eleven (11) level 4. There is one senior staff member who is the service assessor for the education programme implemented. The programme is overseen by the nurse manager and/or the clinical manager. Records are maintained.
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 documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place with staff interviewed reporting that good access to advice is available when needed. Care staff interviewed reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and a review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff being replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 registered nurse coverage at all times. A contingency plan is in place to ensure RN cover is available.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Records in reviewed files were legible with the name and designation of the person making the entry identifiable. There is a staff signatures register in place for reference when required. Previous area of improvement was addressed.

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	A safe system for medicine management using an electronic system was observed on the day of audit. The interviewed caregivers demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage and current medication management competencies were sighted in the reviewed staff documents. An RN was observed administering medications and correct and safe medicine management procedures were demonstrated. The medicine trolley was kept within sight. Appropriate documentation was completed. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RNs check medications against the prescription. There were no expired medications on site. Unwanted medicines are returned to the pharmacy, they are collected from the facility by the pharmacy staff. Clinical pharmacist input is provided on request. Medication fridge temperatures were being monitored daily and where anomalies were noted, corrective actions were implemented; records of this were sighted. There were controlled drugs 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. Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. Regular three-monthly medication reviews were completed, with electronic records sighted confirming this. Residents' current photos, allergies and any special instructions were recorded on the electronic prescription charts. There were nine residents who were self-administering medications at the time of audit. Appropriate assessments and regular reviews of residents' competence to do so were completed to ensure this was managed in a safe manner. Medicines were kept in locked drawers or lockboxes in residents' rooms. Interviewed residents confirmed satisfaction with the process. Medication errors were analysed, and corrective actions implemented as required. The previous areas that required improvement regarding security of medications during medication round, recording of reasons for medication refusal and completion of mandatory six-monthly controlled drug checks were addressed.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met	FA	The food service is provided on site by cooks and kitchen hands and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns on a four weekly cycle and has been reviewed by a qualified dietitian within the last two years. Meals were served in respective dining rooms or in residents' rooms if desired by the resident. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration

where this service is a component of service delivery.		issued by the Ministry of Primary Industries (MPI) with an expiry date of 9 October 2020. Food, fridge and freezer temperatures, including for high risk items, were monitored appropriately and recorded as part of the plan. The cooks and the kitchen hands have completed relevant food safety and handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile is 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. Copies of the residents' dietary profiles were sighted in the kitchen records reviewed. Special equipment, to meet resident's nutritional needs, was available. Residents' weights were monitored monthly or more frequently if clinically indicated. Nutritional supplements were provided where indicated and documentation was sighted in reviewed residents' files. The kitchen was clean, pantry stocked well, decanted food was labelled with dates and covered. Cleaning schedules were in place and implemented, signed records were sighted. Interviewed residents and families/whanau confirmed satisfaction with the meals provided. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided. The previous area that required improvement regarding poor shelving condition has been addressed.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Reviewed residents' records evidenced that care provided to residents was consistent with their assessed needs, goals and the plan of care. There was a diverse range of residents and their individual needs were met as confirmed by interviewed residents and family members. The GP interview verified that medical input is sought in a timely manner and that medical orders are followed and care is provided promptly. Care staff confirmed that care was provided as outlined in the documentation. Specialised equipment was provided for residents who require it. A wide range of equipment and resources were available and suited to the levels of care provided.
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	The activities programme is provided by two activities coordinators. An activities assessment is completed for each resident on admission to ascertain residents' needs, interests, abilities and social requirements. The activities coordinator interviewed confirmed that residents' activities participation is monitored daily and significant changes in participation are reported and acted upon. Daily activities attendance records were sighted in the reviewed documents. Activities plans are regularly reviewed to help formulate an activities programme that is meaningful to the residents with input from residents and family members where applicable. Residents and families/whānau are involved in evaluating and improving the programme through discussions in the residents' meetings and as part of satisfaction surveys. The resident's activity needs are evaluated when there is a significant decline in a

		resident's condition and participation and as part of the formal six-monthly care plan review. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered including music entertainment, bowls, quiz, newspaper reading, iPad use, exercises, church services, men's group activities, female group activities, arts and craft. The activities are divided into three groups capturing for different age groups and functioning ability of residents, including high functioning, moderate functioning and low functioning groups. However, all residents are welcome to participate in any group activities if desired as reported by the activities coordinator. Residents and families confirmed satisfaction with the activities programme and confirmed that residents can attend to any activities of choice.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Reviewed residents' long-term care plans evidenced evaluations occur every six months, or as residents' needs change (Refer to 1.3.3.3). Where progress was different from expected, the service responded by initiating changes to the plan of care. Regular evaluation of responses to planned care in short term care plans was evidenced in the documents reviewed. When necessary, unresolved problems were added on to the long-term care plan Residents' care is evaluated on each shift and reported in the progress notes by the caregivers. The RNs review and document in the progress notes daily. Interviewed caregivers reported that any change noted, is reported to the RNs. Interviewed residents and families/whānau confirmed involvement in evaluation of progress and any resulting changes. Family contact records were sighted in the reviewed residents' files.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The area requiring improvement from the previous audit in relation to a sling hoist used for transferring residents not able to be cleaned effectively has been addressed. This hoist has been fully cleaned and painted and can now be easily wiped down for infection control purposes. In addition to this finding the communal showers and toilet doors requiring repair have been repaired/replaced as needed and the small hole in the shower wall was fully relined. Exterior repairs and maintenance are fully completed. A current building warrant of fitness which expires 01 June 2020 was publicly displayed at the entrance to the facility.
Standard 3.5: Surveillance Surveillance for infection	FA	Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme were shared with staff via regular staff meetings and at staff handovers. Staff meeting minutes were sighted to verify this. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the director. Data is benchmarked

is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.		externally within other aged care providers who provide similar services. The infection control coordinator (ICC) reported that benchmarking has provided assurance that infection rates in the facility are below average for the sector. Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The ICC coordinator reviews all reported infections, and these were documented. Interviewed staff confirmed that new infections and any required management plans are discussed at handover to ensure early intervention occurs. No infection outbreak have been reported since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The restraint coordinator is an enrolled nurse who has been in the role for one year. The enrolled nurse was not interviewed on the day of the audit. The restraint register was available and reviewed. On the day of the audit, six enablers were in use and seven restraints (five bedrails and two wheelchair restraints) were being used by residents. Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, residents' records reviewed and from interviews with staff.

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 1.3.3.3 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 Low	Nursing admission assessments including initial interRAI assessments were completed within three weeks of admission. Long term care plans were completed within three weeks of admission with input from assessment outcomes, residents and family members, and hospital discharge summaries where applicable. Enduring power of attorneys (EPOAs) were involved in the assessment, planning and evaluation processes, where appropriate. Identified needs were planned for in the records reviewed and changes to interventions were completed and implemented when required. Not all interRAI reassessments were completed in a timely manner.	Five out of 58 interRAI reassessments were not completed six monthly as required.	Provide evidence that all interRAI reassessments are completed six monthly. 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, 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.