

Graceful Home Limited

Introduction

This report records the results of a Certification 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 HealthShare 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:	Graceful Home Limited
Premises audited:	Rose Lodge Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 December 2014 End date: 3 December 2014
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:	14

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

A certification audit was undertaken to establish compliance with the Health and Disability Services Standards and the District Health Board Contract. Rose Lodge provided residential rest home care for up to 14 residents with occupancy of eleven on the day of the audit.

The director purchased the service in February 2014 and had experience in managing and leading a home care service. Staffing was appropriate to support the needs of residents with a registered nurse who provided on site support.

There was a documented quality and risk management programme with refurbishment and renovations completed since the last audit.

Twelve areas of improvement were 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.	Green	Standards applicable to this service fully attained.
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Staff were able to demonstrate an understanding of residents' rights and obligations. This knowledge was incorporated into their daily work duties. Residents were treated with respect and received services in a manner that considered their dignity and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint was available to residents and their family. Complaints were investigated. Staff ensured that residents were informed and had choices related to the care they received.

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 medium or high risk and/or unattained and of low risk.
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Rose Lodge had a documented quality and risk management system. Policies were developed by an independent consultant.

There were human resource policies. Staffing levels were adequate and interviews with residents and relatives demonstrated that they had adequate access to staff when needed. A permanent registered nurse was in the process of being appointed.

Eight improvements are required: cover for the director when on leave, communicating quality data at staff meeting minutes, fully implementing the internal audit programme, notification of authorities in the event of a serious event, maintaining evidence of role descriptions, recruitment, orientation, performance appraisals and aspects of training and ensuring that daily care checklists are completed.

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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Residents were receiving services from suitably qualified and experienced staff. Resident, nursing and medical reviews were conducted within the required timeframes. Care plans evaluations were documented, resident-focused and indicated the degree of response to interventions and desired outcomes. There was sufficient evidence that residents and family were given the opportunity to contribute to care plans.

The medicines management system provided safe and appropriate prescribing, review, storage, disposal and reconciliation. The medicines policy included safe management for residents who were able to self medicate. All medicines were stored appropriately.

Food and nutritional needs of residents were provided in line with recognised nutritional guidelines. Dietary needs of the residents were met.

Three improvements are required: ensure all assessments and care plans include any additional needs, complete medication competencies for all staff that administer medications and increase the activities programme.

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.		Some standards applicable to this service partially attained and of low risk.
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There is a current building warrant of fitness in place. There was a maintenance programme with the director completing maintenance and refurbishment since purchase. Essential emergency and security systems were in place with regular fire drills completed. Call bells were in place.

An improvement is required to ensure ongoing maintenance requirements are met.

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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Documentation of restraint minimisation, safe practice, policies and procedures, and their implementation, demonstrated that services were least restrictive. The service was not using restraints or enablers.

Systems were in place to ensure assessment of residents was undertaken regarding possible needs for enablers or restraints. Resident's files reviewed demonstrated risk assessments and monitoring processes were implemented.

Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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Infection control was appropriate to the size and complexity of the organisation. The infection control programme was implemented. The service had a process in place for completing surveillance of infections. Surveillance results were reported and collated.

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	36	0	6	3	0	0
Criteria	0	81	0	9	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	<p>FA</p>	<p>Staff received education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. Staff training was last conducted in August 2013.</p> <p>Interviews with the two health care assistants, the director and the registered nurse confirmed their understanding of the Code. Everyday practice included aspects of the Code including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents continued to practice their own personal values and beliefs. The information pack provided to residents on entry included how to make a complaint, the code of rights pamphlet and advocacy information.</p> <p>The auditors noted respectful attitudes towards residents on the day of the audit.</p>

<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	<p>FA</p>	<p>Residents and their families were provided with all relevant information on admission. Discussions were held regarding informed consent, choice and options regarding clinical and non-clinical services. Written informed consent was obtained for the following: consent for sharing of information, consent for care and treatment, outings and photos. Advance directives were used with residents signing the form appropriately.</p> <p>Discussion with residents and a family member identified that the service actively involved them in decisions that affected their lives. Health care assistants who had been with the service for a long period specifically stated that there was more emphasis on residents being as independent as possible.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office was provided to residents and families. The information was readily available.</p> <p>The diversional therapist, responsible for facilitating the six weekly resident meetings, reported that information was regularly provided to the residents regarding their right to access advocacy services. Staff training on the role of advocacy services was included in training on the Code and was last provided in August 2013.</p> <p>Discussion with family and residents confirmed that the service provided opportunities for the family/EPOA (enduring power of attorney) to be involved in decisions. They also stated that they had been informed about advocacy services.</p> <p>Resident files included information on resident's family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service had an open visiting policy. Residents could have visitors of their choice at any time. The facility was secured in the evenings but visitors could arrange to visit after doors were locked. Family interviewed confirmed they could visit at any reasonable time and were</p>

		<p>always made to feel welcome.</p> <p>Residents interviewed confirmed they were encouraged to be involved in community activities and maintain family and friends networks. Links were also encouraged through church and other community activities e.g. markets. Residents were included in shopping visits and outings with family members.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The organisation's complaints policy was in line with the Code and included time-frames for responding to a complaint. Complaint's forms were easily accessible.</p> <p>A complaints register was place and included the date the complaint was received, a description of the complaint and the date the complaint was resolved. Evidence relating to each complaint was held in the complaint's folder. Two complaints lodged in 2014 were selected for review. There was documented evidence of time-frames being met for responding to these complaints. Residents and family confirmed that they would feel comfortable making a complaint.</p> <p>The director stated that there had been no complaints with the Health and Disability Commission, or other authorities, since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>A registered nurse or the director discussed the Code, including the complaints process, with residents and their family on admission. Residents and family confirmed that rights were upheld by the service. Information regarding the Health and Disability Advocacy Service was clearly displayed. Residents' right to access advocacy services was identified. If necessary, staff stated that they will read and explain information to residents. Information was also given to next of kin or enduring power of attorney (EPOA) to read to and discuss with the resident in private.</p> <p>Five residents and a family member interviewed were able to describe their rights and advocacy services particularly in relation to the complaints process.</p>

<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service had a philosophy that promoted dignity and respect and quality of life. Policies and procedures were aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs were assessed using a holistic approach. The initial and on-going assessment included gaining details of people's beliefs and values. The registered nurse interviewed stated that the care plans were completed with the resident and family member. This was confirmed by residents and family interviewed. Residents were addressed by their preferred name and this was documented in all files reviewed.</p> <p>A policy was available for the staff to assist them in managing resident practices and/or expressions of intimacy and sexuality in an appropriate and discreet manner. Staff had received training around sexuality and intimacy last in May 2013.</p> <p>The service ensured that each resident had the right to privacy and dignity, which was recognised and respected. The residents' own personal belongings were used to decorate their rooms. Discussions of a private nature were held in the resident's room. Health care assistants reported they knock on bedroom doors prior to entering rooms, ensure doors were shut when cares were being given and did not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families interviewed confirmed the residents' privacy was respected.</p> <p>Health care assistants reported that they encouraged the residents' independence by encouraging them to be as active as possible.</p> <p>The service was committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Guidelines for staff to prevent, identify, report and correct any risk to residents and staff from abuse or neglect were provided. There was an expectation that staff would, at all times, work within the organisation's mission statement, values and objectives of service delivery, and have knowledge of legislation relating to human rights and the Code.</p> <p>Cultural and /or spiritual values, individual preferences were identified in resident records. Residents accessed community church services with</p>

		<p>the diversional therapist informing residents that if they wish to access transport, then this could be arranged.</p> <p>There were clear instructions provided to residents on entry regarding responsibilities of personal belongings in their admission agreement.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service implemented the Maori health plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/family to practise their own beliefs were acknowledged in the Maori health plan. Links to local kaumatua services were through the director who identified as Maori.</p> <p>There were no Maori residents living at the facility during the audit. Staff interviewed were aware of the importance of whanau in the delivery of care for Maori residents and have had training around cultural safety in May 2013.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identified each resident's personal needs and desires from the time of admission. This information was used to develop the care plan. Residents and family interviewed confirmed they were involved in the assessment and the care planning processes. It was reported that very few family were actively engaged with the service however the family member interviewed confirmed that the service supported residents with any cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility implemented policies and processes to ensure staff were aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory training included discussions on the staff code of conduct and the prevention of inappropriate care. Job descriptions included responsibilities of the position, ethics, advocacy and legal issues with a job description sighted on staff files. The orientation and employee agreement provided to staff on induction included standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the</p>

		boundaries of the health care assistants' role and responsibilities.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies aligned with the health and disability services standards and were reviewed by an external consultant at least two yearly. An on going training programme was implemented. The registered nurse was on site for at least 20 hours a week. Residents and one family member interviewed expressed a high level of satisfaction with the care delivered. The general practitioner interviewed reported that the care provided was of a good standard.</p> <p>Key projects included refurbishment of the facility, new equipment and appliances purchased and the appointment of a diversional therapist.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alerted staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurred. These procedures guided staff on the process to ensure full and frank open disclosure was followed. Family were informed if the resident had an incident, accident, a change in health or a change in needs. This was evident in 10 of 10 accident/incident forms sampled. Family contact was also recorded in residents' files.</p> <p>The family member interviewed confirmed they were kept informed. Family also confirmed that they were invited to the care planning meetings and were invited to attend the six weekly resident meetings.</p> <p>Interpreter services were available when required from the District Health Board. While there were two residents who were mostly non-verbal, both were able to be communicated with and both made themselves understood. The information pack was available in large print.</p> <p>Staff had training on communication in 2013 and the complaints process in July 2014. This included information around open disclosure.</p>

<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Rose Lodge had a clear mission, values and goals. The director was in the process of reviewing these to personalise the mission statement to the service. The facility was purchased in February 2014 and could provide care for up to 14 rest home residents. The director had been a senior caregiver in a psycho – geriatric area for 15 years and owned a home care company for private clients. The director described a passion for the elderly and for providing services with compassion. The director stated that they have an external accountant completing the financial oversight of the business.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>PA Moderate</p>	<p>In the absence of the director, the relieving registered nurse was in charge. The registered nurse had three years' experience in hospital nursing and a year's experience in providing rest home care while completing New Zealand nursing training. The director was in the process of employing the registered nurse into a permanent position. This will include the role of second in charge. The previous registered nurse had left the day prior to the audit and the relieving registered nurse had provided cover previously for the service.</p> <p>An improvement is required to ensure that sufficient cover is arranged during the temporary absence of the director.</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>	<p>PA Low</p>	<p>The service implemented organisational policies and procedures to support service delivery. All policies were subject to reviews as required and these were completed in a timely manner by an external consultant. Policies were linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. New and revised policies were presented to staff to read and sign to stay that they have read and understood.</p> <p>An external consultant had documented the business, quality and risk management plan and the director and registered nurse envisaged reviewing these in December in line with planned six monthly reviews.</p> <p>Service delivery was monitored through the collection of quality data. The internal audit programme had been implemented up to January</p>

		<p>2014 with corrective action plans documented to that point. An improvement is required regarding reinstatement of the internal audit programme and ensuring that all aspects of the quality and risk management programme were discussed and analysed through the staff meeting.</p> <p>The organisation had a risk management programme in place. Health and safety policies and procedures were documented. There was sufficient evidence that any hazards identified were addressed.</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>The director was aware of situations in which the service would need to report and notify statutory authorities including police attending the facility, unexpected deaths, critical incidents and infectious disease outbreaks. The service was committed to providing an environment in which all staff were able, and encouraged, to recognise and report errors or mistakes and were supported through the open disclosure process. This was confirmed in interviews with staff and the director with an improvement required to ensure that appropriate authorities are notified when required. Staff received education at orientation on the incident and accident reporting process. Staff understood the adverse event reporting process and their obligation to document all untoward events.</p> <p>Ten incident reports were selected for review. All incidents were graphed monthly, reviewed and signed off by the director. An improvement is required to ensure that evidence of essential notifications is maintained</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>All staff were required to undergo an orientation programme. Health care assistants were paired with a senior caregiver for shifts or until they demonstrated competency on a number of tasks including personal cares. The organisation had a mandatory education and training programme with sessions held monthly. Staff attendances were documented and there was evidence of good staff attendance. Health care assistants stated that they value the training. Education and training hours exceeded eight hours a year. There was also an annual</p>

		<p>appraisal process.</p> <p>The relieving registered nurse had a current annual practising certificate. Visiting practitioner's practising certificates included the general practitioner, podiatrist and pharmacists.</p> <p>Three improvements are required regarding human resources. Full records of recruitment, orientation, training and performance appraisals have not been maintained.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There were currently 10 staff including the director, registered nurse, a diversional therapist, administrator, two cooks and health care assistants</p> <p>The staffing policy was the foundation for work force planning. Staffing levels were reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that met resident acuity and bed occupancy.</p> <p>The rosters included a health care assistant on each shift. The director was on site for at least five days a week and the relieving registered nurse was currently contracted to provide 20 hours a week. A relieving registered nurse was continuing to provide cover until a permanent nurse was employed. The director and registered nurse both confirmed the arrangement and the director was actively recruiting for the role.</p> <p>Residents and the family member interviewed confirmed staffing is adequate to meet the residents' needs.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	PA Low	<p>The service retained relevant and appropriate information to identify residents and track records. This included comprehensive information gathered, at admission, with the involvement of the family. There was sufficient detail in progress notes to identify residents' on-going care history and activities apart from the daily care charts which has not been consistently maintained and an improvement is required.</p> <p>There were policies and procedures in place for privacy and</p>

		<p>confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files and resident information could be accessed in a timely manner. Files were locked in a filing cabinet. Information containing sensitive resident information was not displayed in a way that can be viewed by other residents or members of the public.</p> <p>Entries to records were legible, dated and signed by the relevant health care assistant, registered nurse or other staff member including designation. Individual resident files demonstrated service integration. This included medical care interventions. Medication charts were in a separate folder with medication. This was appropriate to the service.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Policies and procedures for entry criteria, assessment and entry screening were recorded and implemented. The registered nurse confirmed that service information was communicated to residents, family, relevant agencies and staff. The service provided information to referral sources and operated 24 hours a day, seven days per week.</p> <p>The admission agreement defined the scope of services and included the contractual requirements. Files sampled confirmed signed and dated admission agreements. The registered nurse interviewed confirmed access and entry processes were followed. The service had an admission pack available for residents and their family.</p> <p>Five residents' files sampled demonstrated needs assessments were completed for the appropriate level of care. This was confirmed during interview with the general practitioner and the registered nurse. Interviews with residents confirmed that the admission process was conducted by staff in timely manner and relevant admission information was provided.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Service providers identified, documented and minimised risks associated with each resident's transition, exit, discharge and or transfer. This included expressed concerns of the resident and the family. This was confirmed during interview with the registered nurse and health care assistants. The service used a specific transfer form to document areas of potential risk which included personal details of the</p>

		resident, risk assessment information, the long term care plans and a copy of the medicines chart and administration record.
<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>	<p>PA Moderate</p>	<p>Visual inspection of the medication area evidenced an appropriate and secure medicine administration system. The area was free from heat, moisture and light, with medicines stored in original dispensed packs, in a locked medicines trolley. There were no controlled drugs stored in the facility.</p> <p>Ten medicine charts were sampled. Medicines charts listed all medications the resident was taking, including name, dose, frequency and route to be given. Charts were signed by the GP. All entries were dated and allergies recorded. All charts had photo identification. Discontinued medicines were signed and three monthly GP reviews were evident.</p> <p>Medication administration was observed. The staff member checked the identification of the residents, completing cross checks of the medicines against the script, administering the medicines and then signing off after the resident took the medicines.</p> <p>Education in medicine management was conducted in June 2014. Six staff were authorised to administer medications. This required completion of a medication competency test. The competency process was not complete for two staff members and an improvement is required.</p> <p>There were no residents who self-administered medicines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>Food policies, procedures and services were appropriate to the service setting, providing summer and winter menus that rotated every four weeks. The menu was developed by a dietitian. This was confirmed by the cook during interview. Food procurement, production, preparation, storage and disposal complied with requirements. Stored food was sighted. The cook kept daily records of fridge, freezer and chiller temperatures and records were sighted. Food temperatures were monitored and records maintained. All kitchen staff completed food</p>

		<p>safety training.</p> <p>Resident's individual dietary needs were identified, documented and reviewed as part of the long term care plan review. The cook was informed when residents' dietary needs changed. This was confirmed during interview and sighted in copies of dietary assessments.</p> <p>Additional food and snacks were available. This was confirmed during resident and family interviews. Residents were offered fluids throughout the day. Residents' files sampled demonstrated monthly monitoring of individual resident's weight. Family surveys confirmed they were satisfied with food services.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The scope of services provided was identified in the admission agreement and communicated to prospective residents and their families. This was confirmed during the interview with the registered nurse.</p> <p>The service had a system in place for informing people who were declined entry. This was confirmed during interviews with the registered nurse and director. The registered nurse stated residents would only be declined entry if not within the scope of the service or if there was no bed available. It was reported that those declined entry were informed of the reasons and referred back to the needs assessment service coordination services.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Resident files reviewed evidenced risk assessments. Initial care plans were completed on admission, signed by the registered nurse and by the resident or family. This was confirmed in staff and resident interviews. Needs, outcomes and goals in the long term care plans were consistent to the needs, goals and outcomes in the risk assessments. Assessments were conducted in a timely manner and risk assessment findings were reflected in the long term care plans.</p>
Standard 1.3.5: Planning	FA	Long term care plans sighted were individualised, personalised and up-

<p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>to-date. Long-term and short-term goals were identified by the residents and staff and were reviewed at least six monthly or as needs change. Residents interviewed confirmed they had input into their care planning and review.</p> <p>Staff members interviewed confirmed care plans reflected the residents' current needs. There was evidence that the clinical care, treatment, support and interventions provided were current. Risk assessments were recorded on the long term care plans.</p> <p>The general practitioner (GP) was responsible for the care of the majority of the residents. This was confirmed during interview. The GP confirmed satisfaction with the level of care provided.</p> <p>An improvement is documented in criterion # 1.3.3.3 regarding long term care plans for residents who have a behaviour of concern.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>Documentation and observations made of the provision of services and/or interventions, demonstrated that consultation and liaison was occurring with other services. Referrals to other agencies were sighted in resident files. Visual inspection evidenced that there were adequate continence and dressing supplies.</p> <p>Interview with the GP, the registered nurse and review of residents' files confirmed that long term care plans record interventions based on assessed needs, desired outcomes and goals. The long term care plans included cultural needs, sexuality, spiritual needs. Residents or family were signing the care plans in demonstration of their participation.</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>PA Low</p>	<p>The facility had a diversional therapist (DT) who had been with the facility June 2014. The DT was interviewed and worked 20 hours per week Thursday to Sunday five hours per day. The DT was responsible for the development of the programme including additional activities for residents who were younger than 65. The service had only one resident under 65. Sufficient equipment was provided. Activities attendance records were maintained.</p> <p>Residents, family and staff interviewed confirmed the activities</p>

		<p>programme included input from external agencies, supports ordinary, unplanned and spontaneous activities. Residents' files sampled demonstrated that the individual activities service plans were current and demonstrated support was provided. Current residents' activities assessments were sighted in all residents' files sampled. Residents participated in group and one-on-one activities where appropriate. This was observed during the audit.</p> <p>Residents interviewed confirmed their past activities were considered and their enjoyment of the activities they choose to participate in. However, residents reported that the activities programme did not meet their needs for three days of the week.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Evaluations are documented, resident focussed and indicate the degree of response to interventions and the progress towards meeting the resident's goals.</p> <p>One resident file sampled included a comprehensive evaluation of the levels of care delivered during an acute problem. A short term plan for the management of the problem was documented. However, specific needs relating to the management of behaviours of concern and the possible need for reassessment was not specifically identified in the long term care plan. An improvement has been documented in criteria # 1.3.3.3.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Resident documentation and records sampled confirmed that residents had choices regarding access and referrals to other health or disability services. Referral forms and letters to nursing and medical specialists were sighted. This included letter to the needs assessment team and specialist services at the Auckland District Health Board (ADHB). The service maintained effective family communication. This was confirmed during resident and family interviews and supported in resident records such as progress notes.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances were in place. The incident reporting system would be used if there were any complaints around waste management. The director stated that there had been no incidents around this since the purchase in February 2014. Policies and procedures specified labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage.</p> <p>Information around chemicals used was located in the laundry. The hazard register was current. Staff could describe safe and appropriate handling of waste and hazardous substances. Only domestic products which were purchased from the supermarket were used for cleaning and laundry processes. These products were clearly labelled and appropriately stored. There was also a secure garage on the section where petrol and garden chemicals were stored.</p> <p>All staff were required to complete training regarding the management of waste during induction. Chemical safety training was a component of the in service programme. The most recent training on waste and chemical substances was conducted in June 2013.</p> <p>The provision and availability of protective clothing and equipment, appropriate to the recognized risks, was provided. For example: goggles/visors, gloves, aprons, footwear, and masks. During a tour of the facility protective clothing and equipment was observed in all possible risk areas.</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>	<p>PA Low</p>	<p>A current building warrant of fitness was posted in a visible location at the entrance to the facility (expires September 2015). There had been no building modifications since the last audit however there had been significant refurbishment of bedrooms and communal spaces. The refurbishment was continuing with some areas identified as requiring further maintenance and improvements. There was a planned on going maintenance schedule implemented and any receipts of work completed were retained with the director working with the building owner to address issues.</p> <p>Interviews with health care assistants, the registered nurse and the</p>

		<p>director confirmed that there was adequate equipment. Shower chairs and scales were available. The required checks of medical equipment was last completed in October 2013. There was a test and tag programme two yearly and this was up to date by virtue of the new owner purchasing all new appliances and equipment for the service.</p> <p>There were quiet areas throughout the facility for residents and visitors to meet and there were areas that provided privacy when required. There was safe outside areas that were easy to access for residents and family members including an outside table, chairs and shade. There was an external covered deck which was used by the residents who smoked. This was a very social area and several residents were sighted spending time in this area, smoking, reading and chatting.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There were adequate numbers of accessible toilets/bathing facilities. This included toilets conveniently located close to communal areas. All had locks or other methods of noting if the room was engaged to ensure privacy for residents when in use.</p> <p>Appropriately secured and approved handrails were provided in the toilet/shower/bathing areas (refer 1.4.2.4) and other equipment/accessories were made available to promote the residents' independence. Residents interviewed reported that there were sufficient toilets and showers.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There was adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms. Rooms could be personalized with furnishings, photos and other personal adornments. There was sufficient room to store mobility aids such as walking frames.</p> <p>There were two rooms that could be shared between two residents and one sleep out attached to the office. The sleep out had close access to the house. One double bedroom was not occupied and the other double rooms had one resident. There were curtain rails that were available should the room be shared.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The building had a lounge/dining area and was large enough with appropriate floor coverings in each area. The rooms was easily accessed by residents and staff. The lounge areas were designed so that space and seating arrangements provided for individual and group activities. The activity programme was being offered in the lounge on the day of the audit. Residents were able to access areas for privacy if required including a large outdoor table and chairs and an external covered deck area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry was completed by the health care assistants. Cleaning was monitored by the director and registered nurse. Chemicals were locked away when not in use. The health care assistants were observed to have the trolley in the room with them when cleaning.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An evacuation plan was approved by the New Zealand Fire Service on 20 June 2012. There had been no building reconfigurations since this date. An evacuation policy on emergency and security situations was in place.</p> <p>A fire drill takes place six-monthly with these up to date in 2014. The orientation programme included fire and security training. Staff confirmed their awareness of emergency procedures. There was always one staff member with a first aid certificate on duty. This was confirmed through review of the roster, review of staff files and interview with the director.</p> <p>All required fire equipment was sighted and all equipment had been checked within required timeframes. A civil defence plan was in place. There were adequate supplies in the event of a civil defence emergency including water, blankets, extra linen including towels and face cloths and access to a gas BBQ. The service had access to food in the event of an emergency.</p> <p>An electronic call bell system was in place. There were call bells in all residents' rooms, residents' toilets, and communal areas including the</p>

		hallways, dining room and lounge area. Systems were in place to ensure the facility was secure for the residents and staff. External lighting was adequate for safety and security with exit lights newly installed over exit doors.
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There were procedures to ensure the service was responsive to resident feedback in relation to heating and ventilation, wherever practicable. Documentation and visual inspection confirmed that the residents were provided with adequate natural light, safe ventilation, and an environment that was maintained at a safe and comfortable temperature. The central heating had been upgraded by the new owner. There was a designated external smoking area. Family and residents interviewed confirmed the facility was maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The Infection control program was maintained and updated by the organisation. The infection control coordinator was the registered nurse. The registered nurse was interviewed and reported that the responsibilities included monitoring and surveillance of infections on a monthly basis, collating the information and reporting to management. The infection control coordinator did not have a defined role description identifying these responsibilities and an improvement has been documented in criteria # 1.2.7.3.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Infection control meetings were held as part of the staff meeting. This was confirmed during interview of the infection control coordinator. The infection control coordinator was responsible for internal training of staff and implementation of the infection control programme.</p> <p>Signs relating to hand washing processes and hand-washing instructions were displayed in the nurses' station and at hand-basins. The infection control coordinator kept an infection control resource folder to assist in infection control training and implementation of the programme. Staff members interviewed confirmed their participation in</p>

		<p>infection prevention and control within the facility.</p> <p>Interview with the infection control coordinator confirmed surveillance was carried out in accordance with the service's infection control policies. The management of infections included residents having short term care plans. This was confirmed in resident records sighted.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>Policies and procedures for the prevention and control of infection complied with relevant legislation and current accepted good practice. The infection control policy and programme was reviewed annually. This was evident and confirmed during interview with the infection control coordinator. The service had access to micro-biologists at the laboratory and the infection control nurse specialist at the Auckland District Health Board (ADHB) if required.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>A review of the education folders confirmed that training was provided by the infection control coordinator in November 2014. Training included hand hygiene. Interviews with residents and a family member confirmed they were aware of the importance of hand washing and the use of alcohol gels. The service offered education and training regarding hand washing procedures to residents in an informal manner during service delivery.</p> <p>The infection control coordinator had not completed additional infection control training specific to the role and an improvement has been documented in criteria # 1.2.7.5.</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>Surveillance activities were appropriate for the size and scope of the service. The infection control coordinator collected information regarding the resident, the date of the infection, the site of the infection, signs and symptoms of the infection, whether standardised criteria for infections were being met, whether a specimen was sent, the outcome of the specimen, whether antibiotics were prescribed and if follow-up was required. The service also recorded additional nursing interventions that may be required. They recorded the need for change in antibiotics</p>

		treatment, the total infection days and number of days on antibiotics. Surveillance data was summarised and the analysis was expressed in graphs.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The service demonstrated that the use restraints and enablers were actively minimised. The restraint register was sighted. There were no restraints or enablers in use. Staff interviews and records confirmed that restraint minimisation and safe practice, as well as challenging behaviour, training took place in June 2014.</p> <p>The process for assessment and evaluation of restraint and enablers included that enabler use is voluntary.</p>

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 1.2.2.1</p> <p>During a temporary absence a suitably qualified and/or experienced person performs the manager's role.</p>	PA Moderate	<p>Cover for the director when on leave had been partially organised. The director had planned leave for January 2015 and was putting in place a registered nurse to be employed who will provide the second in charge function. The director reported they will remain in contact with the service even while on leave. The current registered nurse was relieving and was in the process of being permanently employed. The registered nurse had limited experience in aged care and the director stated that further back up would be provided if required.</p>	<p>Suitable cover, in the absence of the director, has not been confirmed.</p>	<p>Provide evidence that sufficient cover has been organised prior to the director taking leave in 2015.</p> <p>30 days</p>
<p>Criterion 1.2.3.1</p> <p>The organisation has a quality and risk management system which is understood and</p>	PA Low	<p>There was documented evidence of communication with staff and the director through six weekly staff meetings and through six weekly resident meetings. Staff</p>	<p>Not all aspects of the quality and risk management programme are discussed and</p>	<p>Provide evidence that all aspects of the quality and risk management programme is reviewed and analysed through</p>

implemented by service providers.		meetings include some discussion of the quality programme. This did not include an analysis of results.	analysed through staff meetings.	the staff meeting. 90 days
<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	Service delivery was monitored through complaints, review of incidents and accidents, satisfaction surveys, surveillance of infection. An internal audit programme was documented. The internal audit programme had been implemented to January 2014 with corrective action plans documented to that point. Two internal audits had been completed since January 2014. The last resident satisfaction survey took place in August 2013. Areas for improvement identified on corrective action plans were not consistently signed off as resolved.	Internal audits have not been completed as per the internal audit schedule. Corrective actions are not always signed off as resolved.	Complete internal audits as per the internal audit schedule and ensure corrective actions are signed off as resolved. 90 days
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	There had been an incident that resulted in serious harm. This had included a letter to the general practitioner providing information around the incident. The director stated that the registered nurse had informed the District Health Board and the Ministry of Health however documentation was not found relating to this. The previous registered nurse was not able to be contacted for confirmation. The director was aware of reporting requirements to relevant authorities when incidents resulting in serious harm occur.	There is insufficient evidence that appropriate authorities are notified following a serious event.	Maintain evidence that the appropriate authorities have been notified following an incident. 90 days

<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	<p>PA Low</p>	<p>Five staff files included the following documentation: signed contracts, job descriptions for health care assistant and registered nurse roles, training records and a record of visa requirements if required. First aid certificates were held in the staff files. The director stated that reference checks were completed verbally but not documented. The administrator stated that all police checks have been requested however the service was waiting for two of these to be returned. One of five files included a documented application form. The role of the infection control coordinator and restraint coordinator has not been defined.</p>	<p>Evidence of police checks and reference checks has not been maintained. Not all roles have been defined.</p>	<p>Ensure that all documentation related to the recruitment process is documented and kept in staff files. Ensure all roles are defined.</p> <p>180 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	<p>PA Low</p>	<p>Staff undergo an orientation programme. Evidence of orientation was sighted in three of five staff files.</p>	<p>There is insufficient evidence that all staff have completed the orientation programme.</p>	<p>Ensure that all staff have completed orientation.</p> <p>180 days</p>
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>PA Low</p>	<p>There was an annual appraisal process documented in the policy manual with an associated template. The director was aware that staff were expected to have an annual performance appraisal but stated that as there had been new ownership, the process had not been able to be completed. Two of two staff (who are due for a performance appraisal) did not have a current one on file.</p> <p>There was a training calendar and training had been completed in line with the</p>	<p>Not all training and performance appraisal requirements have been met.</p>	<p>Ensure that all staff have an annual performance appraisal. Ensure that all staff receive training on abuse and neglect and that the registered nurse has infection control training relevant to role.</p> <p>180 days</p>

		schedule, however the schedule did not include abuse and neglect (as required). Training had not been provided around abuse and neglect since 2011. The registered nurse did not have additional infection control training.		
<p>Criterion 1.2.9.1</p> <p>Information is entered into the consumer information management system in an accurate and timely manner, appropriate to the service type and setting.</p>	PA Low	Daily care checklist were expected to be completed by health care assistants. This included completion of daily cares for example showers, bowels etc. These were mostly up to date.	Daily care checklists do not always document when cares have been completed.	<p>Ensure that the daily care checklists are completed at the end of each shift and as changes occur.</p> <p>60 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Moderate	The service had six staff members that were trained to administer medicines; however annual competencies were not signed off for two staff members. This included one health care assistant and the registered nurse.	Not all staff members responsible for medicines management have competencies recorded.	<p>Provide evidence that all staff members responsible for medicines management have completed annual medication competencies.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>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.</p>	PA Moderate	The tracer resident presented with a variety of challenging behaviours, i) The level of challenging behaviour may be outside the scope of the service and ii) the service did not have processes in place to monitor challenging behaviour in order to identify challenging behaviour management strategies.	The resident requires a needs assessment by NASC. One resident who had a behaviour of concern did not have the relevant behaviour management plans.	<p>When a residents' behaviour seems outside the scope of care delivered, the resident requires a needs assessment by NASC. Implement strategies for monitoring and management for residents who demonstrate a behaviour of concern.</p> <p>7 days</p>

<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	<p>PA Low</p>	<p>Residents participated in a wide variety of activities and the activity programme included additional activities for younger residents. The activities programme was planned from Thursday to Sunday; however resident interviews confirmed they missed not having activities on Monday, Tuesday and Wednesday.</p>	<p>Residents verbalise they do not have a sufficient number of planned activities throughout the week.</p>	<p>Ensure that the activities programme meet the needs of residents.</p> <p>90 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>	<p>PA Low</p>	<p>The new owner had attended to key areas that were identified as requiring repair work. This included fixing of floors, improved access to the medication/file area, new kitchen appliances, and repairs to the air conditioning unit. There were some areas remaining which required further improvements. This included the laundry, one toilet that had rotted and a seat in the shower that was coming away from the wall. There was also a tear in the carpet in one bedroom. The director had already identified these areas required further maintenance. The carpet was due to be replaced in 2015. These areas are not identified as causing residents' immediate danger.</p>	<p>Not all maintenance improvements have been completed.</p>	<p>Repair areas in the laundry, shower and one toilet and ensure that the carpet in one bedroom is repaired.</p> <p>180 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.