

# New Aged Care Limited

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	New Aged Care Limited	
<b>Premises audited:</b>	Glenhaven Resthome	
<b>Services audited:</b>	Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 7 November 2016	End date: 7 November 2016
<b>Proposed changes to current services (if any):</b>	Nil	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	17	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Glenhaven Rest Home can provide care for up to 18 residents requiring care at rest home level with 17 residents on the day of audit. This surveillance audit has been undertaken to establish compliance with a sub-set of the relevant Health and Disability Services Standards and the district health board contract.

The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

The owner/manager is responsible for the overall management of the facility and is supported by the caregivers, a clinical nurse advisor and a registered nurse. Service delivery is monitored.

The service has addressed improvements required at certification to the following: medication reconciliation and documentation of indications for use for as required medication.

Improvements are required to the following: performance appraisals for staff, reviewed activity plans for residents; documentation of some aspects of medication administration and staff competencies to give medication.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff interviewed are able to demonstrate an understanding of residents' rights and obligations including the complaints process. Information regarding the complaints process is available to residents and their family and complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident with this recorded in the resident file. Residents and family state that the environment is conducive to communication including identification of any issues.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The service has a documented quality and risk management system that supports the provision of clinical care and support at the service. Policies are reviewed at least two yearly and as required with monthly resident and staff meetings in place.

There are human resource policies documented around recruitment, selection, orientation and staff training and development. Each staff member has a file that includes an agreement, confirmation of criminal vetting and evidence of orientation and training on file.

Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

There is a documented quality and risk management system and all aspects of service delivery are reviewed by a clinical advisor.

## 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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There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. Resident files reviewed indicate that the resident is reviewed by the general practitioner monthly to three monthly as required.

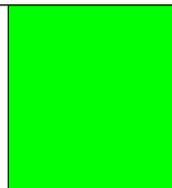
Planned activities are appropriate to the group setting. The residents and family interviewed confirm satisfaction with the activities programme.

There is a medicine management system in place with regular and as required medication administered as prescribed.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met.

## 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.

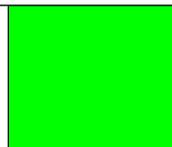


Standards applicable to this service fully attained.

All building and plant comply with legislation with a current building warrant of fitness in place. A preventative and reactive maintenance programme includes equipment and electrical checks.

## 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.

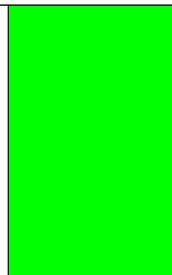


Standards applicable to this service fully attained.

Restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There are no restraints or enablers in use in the facility.

## 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.

Infection prevention and control policies and procedures are adequately documented. There is a designated infection control co-ordinator (registered nurse/clinical manager) who is responsible for ensuring monthly surveillance is completed.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	13	0	2	1	0	0
<b>Criteria</b>	0	36	0	3	2	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<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 and procedures is in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and includes periods for responding to a complaint. Complaint's forms are available in the facility.</p> <p>A complaints register is in place and the register includes the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. Evidence relating to each lodged complaint is held in the complaint's folder. Three complaints were tracked and the review indicates that all timeframes taken to inform the complainant and resolve the issues raised were met.</p> <p>Residents and family members all state that they would feel comfortable complaining. Residents are also able to describe their understanding of the right to complain.</p> <p>There have not been any complaints forwarded by the Health and Disability Commission or other external agencies since the last audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate</p>	FA	<p>Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accidents/incidents that occur. These</p>

<p>effectively with consumers and provide an environment conducive to effective communication.</p>		<p>procedures guide staff on the process to ensure full and frank open disclosure is available.</p> <p>If the resident has an incident, accident, has made a complaint or has a change in health or a change in needs, then family are informed as confirmed in a review of accident/incident and complaints forms and in the resident files.</p> <p>Files reviewed include documentation around family contact. Interviews with a family member confirm they are kept informed.</p> <p>Interpreting services are available when required from the District Health Board. There are no residents requiring interpreting services at the time of the audit. All residents interviewed confirm that staff are approachable and communicate in a way that meets their needs.</p> <p>An information pack is available in large print and staff interviewed advised that this could be read to residents.</p> <p>Residents and family interviewed are very satisfied with support and cares provided.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The owner/manager provides operational and strategic leadership for the service. There is a documented mission, values and goals. The facility can provide care for up to 19 residents requiring rest home level care. The owner/manager is on site four days a week. The registered nurse provides clinical support and oversight of the service and has over three years' experience in aged care nursing. The registered nurse has clinical experience overseas in tutoring and in clinical practice in a hospital.</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>FA</p>	<p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews with these reviewed last in 2016 and on an ongoing basis. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, contracts, and evidenced-based best practice guidelines. The policy around wounds has been updated to include information provided by the Ministry of Health around pressure injuries. A document control system is implemented.</p> <p>Service delivery is monitored through complaints, review of incidents and accidents, surveillance of infections and implementation of reviews against all aspects of the service by a clinical advisor. Corrective action plans are documented with evidence of resolution of issues. Quality improvement data is analysed and discussed at staff meetings. All staff interviewed report that they are kept informed of quality improvements and all aspects of the quality programme are tabled for discussion at the meetings. The three-monthly review of care is also discussed at meetings.</p>

		<p>There are monthly resident meetings for those who wish to attend. Residents interviewed stated that these are useful.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are in place for the service, which includes a documented hazard management programme and a hazard register for the service. Any hazards identified are signed off as addressed or risks are minimised or isolated. An organisational risk management plan is documented. The plan is being updated to include compliance/risks related to the Health and Safety at Work Act 2015. Risks and related actions are monitored and reviewed.</p> <p>There is an annual satisfaction survey for residents and family with this last completed by residents in 2015. There are few residents or family able to respond to the satisfaction survey.</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>	FA	<p>The registered nurse is 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 is 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 registered nurse. The registered nurse can describe how appropriate authorities are informed if major or sentinel events occur.</p> <p>Staff receive 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>Five incident reports were selected for review. All incidents are documented in the analysis of the incident data and reviewed and signed off by the registered nurse.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>Human resource policies and processes are in place. The registered nurse (clinical nurse manager) and the clinical advisor have a current annual practising certificate with a copy on file. Current visiting practitioners' practising certificates reviewed are current and include that of the general practitioner. Staff files include employment documentation such as job descriptions, contracts and appointment documentation on file for permanent staff however an improvement is required to a contract for the relief staff.</p> <p>Reference checking for new staff occurs as sighted on files reviewed. Criminal vetting is completed with the original form destroyed and a register documented that confirms that there are no issues for the potential staff member. Roles have been defined for staff with a relevant job description on</p>

		<p>each file.</p> <p>Most staff files reviewed have a current performance appraisal on file.</p> <p>An orientation programme is available for staff. Staff files show completion of orientation and new staff can describe the process of induction. Training is identified on an annual training plan. Evidence of training is held for all staff, with folders of attendance records retained for each staff member. A review of attendance records confirms that staff do attend the training including night staff. At times, nurses from the district health board provide the training. All staff have completed at least eight hours of relevant training for their role. The registered nurse has completed training for interRAI assessment.</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 are 19 staff including the owner/manager, owner, registered nurse, clinical nurse advisor, activities coordinator, cleaners, cook and caregivers employed in the service.</p> <p>The staffing policy is 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 reflect staffing levels that meet resident acuity and bed occupancy. Staff are replaced on duty if the designated staff member is on leave.</p> <p>The rosters included a caregiver on each shift with a second caregiver for three to four hours in the morning and afternoon. The owner/manager is on site for at least four days a week and the registered nurse is contracted to provide 30 hours a week. The registered nurse (clinical manager) is available on call.</p> <p>Residents and the family member interviewed confirmed staffing is adequate to meet the residents' need. This is reflected in the staff ability to answer call bells within two minutes as stated by residents.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>Medication areas, including controlled drug storage areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. One resident self-administers medication on the day of the audit and a secure place to store medication is available. Reconciliation of medicines occurs as per policy.</p> <p>All staff authorised to administer medicines have competencies however some are out of date and the registered nurse (clinical manager) does not have a current competency.</p> <p>The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered. Administration records are</p>

		<p>maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Medicine charts evidence legibility, as required (PRN) medication is identified for individual residents and correctly prescribed and three monthly medicine reviews are conducted. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given). Residents' medication files evidence that discontinued medicines are signed and dated by the general practitioner.</p> <p>Improvements are required to documentation of controlled drugs and residents' photo identification.</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>	FA	<p>The food service policies and procedures are appropriate to the service setting with a menu reviewed by a dietitian. The cook has completed food safety training. The service is currently recruiting for a second cook and a caregiver who has been a cook in the past is covering food services for one day a week.</p> <p>The cook confirmed they are aware of the residents' individual dietary needs with these documented on a register. The residents' dietary requirements are identified, documented and reviewed with the review held in the resident file. The kitchen staff state that they are informed if resident's dietary requirements change.</p> <p>The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.</p> <p>The food temperatures are recorded daily with these within normal range. Fridge and freezer temperatures are taken and are within normal range. All food is covered, dated and food is covered and off the floor.</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>	FA	<p>The residents' care plans evidence interventions based on assessed needs, desired outcomes or goals of the residents. Short-term care plans are documented for short-term needs such as infections and wounds. There is evidence that these are linked to the long-term care plan.</p> <p>The general practitioner documentation and records are current. In interviews, residents and family confirmed that the resident's current care and treatments met their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</p>

<p><b>Standard 1.3.7: Planned Activities</b></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 activities coordinator confirms the activities programme meets the needs of the service group and the service has appropriate equipment. The activities coordinator has been providing activities for 20 hours a week with a new staff employed to take over the provision of activities. They are expected to offer 16 hours of activities, five days a week.</p> <p>An activities assessment is completed on entry to the service and goals and a plan documented. Attendance records are maintained with a monthly evaluation of the activities for each resident. Regular exercises and outings are provided for residents and all residents are very active in the community. Most interviewed stated that they wished to continue with independent activities and did not require group activities.</p> <p>Activities plans are reviewed however these should be reviewed at the same time as the care plans. The activities programme is displayed for the month and activities include arts, crafts, intellectual activities and spiritual offerings.</p>
<p><b>Standard 1.3.8: Evaluation</b></p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Periods in relation to care planning evaluations are documented. The residents' long-term care plans are reviewed six monthly. There is evidence of resident, family and caregiver input in care plan evaluations.</p> <p>The residents' progress records are entered on each shift. When resident's progress is different than expected, the registered nurse contacts the general practitioner as confirmed by the general practitioner interviewed. Short-term care plans are in place in residents' files, when required. The family are notified of any changes in resident's condition as confirmed by the family member interviewed.</p> <p>Care plans are updated when changes occur.</p>
<p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is posted in a visible location at the entrance to the facility (expiry date February 2017). There have been no building modifications since the last audit. The owner/manager completes maintenance with a planned approach to addressing issues. The lounge areas are designed so that space and seating arrangements provide for individual and group activities.</p> <p>Equipment relevant to care needs is available and staff confirm that there is always sufficient.</p> <p>A test and tag programme is in place. Equipment is calibrated.</p> <p>There are safe external areas for residents and family to meet/use and these include paths, seating</p>

		<p>and shade.</p> <p>Fire exit doors are clearly labelled and able to be opened in the event of an emergency.</p>
<p><b>Standard 3.5: Surveillance</b></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>The registered nurse (clinical manager) is responsible for the surveillance programme for the service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis with the information documented in the infection log maintained by the registered nurse. Antibiotic use is documented.</p> <p>There is evidence in monthly staff meeting minutes of discussion around infections noting that there are few infections in the facility. The clinical advisor also reviews the infection control programme including review of trends at three monthly intervals. Residents with infections have short-term care plans mostly completed to ensure effective management and monitoring of infections. Interviews confirm information relating to infections is made available for staff during handover and at staff meetings.</p>
<p><b>Standard 2.1.1: Restraint minimisation</b></p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. There are no residents using enablers in the facility and there is no evidence of use of restraint. Staff confirm that that enablers and restraint are not used.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety as confirmed at staff and management interviews.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	<p>There is a training calendar and training has been completed in line with the schedule. Training sessions are well attended by staff.</p> <p>The registered nurse did not have additional infection control training and has not completed training around pressure injuries.</p> <p>There is an annual appraisal process documented in the policy manual with an associated template. The registered nurse is aware that staff are expected to have an annual performance appraisal and one staff file has a current performance appraisal on file. Performance appraisals have been completed in the past but are no longer current.</p>	Four of five staff files do not have a current performance appraisal on file.	<p>Ensure that all staff have a current performance appraisal on file.</p> <p>180 days</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>All medication charts have a resident's photo in place. Other forms of identification are used by the caregiver administering medication on the day of the audit.</p>	<p>Residents photos do not consistently record the date the photo was taken and confirmation of the true likeness of the resident.</p>	<p>Evidence that residents' photos on the medication charts are dated and confirm true likeness of the resident.</p> <p>90 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>	<p>PA Moderate</p>	<p>One of the three staff who administer medication have a competency on file. Some other staff have completed an annual competency.</p>	<p>Two staff who administer medications do not have a current medication competency on file including the registered nurse who administers medications.</p>	<p>Ensure that staff have an annual medication competency on file.</p> <p>90 days</p>
<p>Criterion 1.3.12.6</p> <p>Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.</p>	<p>PA Moderate</p>	<p>Controlled drugs are prescribed appropriately and there is a storage facility that is a safe in a locked cupboard. Balances checked on the day of audit match those entered into the controlled drug book. In the past there have been weekly stocktakes of controlled medication however these have not been kept up in the last months.</p> <p>Two staff sign the entry in the controlled drug book however only one signs in the administration record.</p>	<p>Stocktakes of controlled medication do not occur weekly.</p> <p>Only one staff signs in the administration record.</p>	<p>in) Ensure that stocktakes of controlled medication occur weekly.</p> <p>ii) Ensure that two staff sign in the administration record when controlled drugs are</p>

				administered.  90 days
<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>	PA Low	Each resident has an assessment and plan around activities.	Activity plans are not reviewed six monthly in line with review of care plans.	<p>Review each activity plan in line with review of care plans and update as changes occur.</p> <p>180 days</p>

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

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

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

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

No data to display
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End of the report.