

Metlifecare Limited - Highlands Hospital

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 The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Metlifecare Limited
Premises audited:	Highlands Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 2 November 2015 End date: 3 November 2015
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:	41

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

Metlifecare Highlands Hospital (Highlands) is one of 26 facilities owned and operated by the Metlifecare group, nine of which have care facilities. Metlifecare Highlands provides rest home and hospital level care for up to 41 residents.

This certification audit was conducted against the Health and Disability Services Standards and the provider's contract with the district health board. The audit process included the review of policies and procedures, the review of staff files, observations, and interviews with residents, families/whānau, management, staff and a general practitioner. Feedback from residents and families/whānau members was positive about the care and services provided.

There are four areas identified for improvement related to maintenance, service information being out of date, incomplete incident and accident follow up information, and not all staff annual appraisals being up to date.

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 demonstrated good knowledge and practice of respecting residents' rights in their day to day interactions. Staff receive ongoing education on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Families interviewed reported that staff work in a caring manner and respect each resident.

There is a resident who identifies as Maori residing at the service at the time of audit. Services are planned to respect the individual culture, values and beliefs of the residents.

Written consents are obtained from the residents' family/whanau, enduring power of attorney (EPOA) or appointed guardians. Signed consent forms were sighted in all residents' files reviewed.

The organisation provides services that reflect current accepted good practice. This is evidenced in the guidelines for service delivery.

The service has a documented complaints management system which was implemented. There is one open complaint which is being appropriately addressed.

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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Metlifecare Limited governing body ensure that business and strategic planning is in place to cover all aspects of service delivery. Highlands Hospital's business plan is personalised to the services offered to ensure residents' needs are met. Regular quarterly reporting against business and quality goals occurs to show how the service is progressing. Overall management of the facility (the care unit and the village) is undertaken by the manager who has been in the position for over three years with clinical care being

overseen by a nurse manager who is a registered nurse. Residents are receiving safe services that are well managed, planned and coordinated. Residents and their relatives reported being very satisfied with the care and services being provided.

Quality and risk management systems are coordinated by a quality team with support from the nurse manager. There is effective and integrated monitoring of all service delivery areas. The service is managing health and safety and risk matters in accordance with current safe best practice and legislation. There have been no serious adverse events. The event reporting system is well established, effective and known by staff.

Recruitment, selection and management of staff meets the requirements of these stand

Consumer information is managed in ways that meets the requirements of the Health Records Standard. Archived or obsolete resident records are being stored safely and securely.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Pre-admission information clearly and accurately identifies the services offered. There is an area for improvement to ensure that the information brochure is given to families when making an enquiry about the service. The service has policies and processes related to entry into the service.

Residents have an initial nursing assessment and care plan developed by the registered nurses (RN) on admission to the service. The service meets the contractual time frames for the development of the long term care plan. When there are changes in the resident's needs, a short term care plan is implemented to reflect these changes. The care plan evaluations are conducted at least six monthly on all aspects of the care plan.

All new residents have interRAI assessments completed and existing residents are updated using interRAI on review.

Residents are reviewed by a GP on admission to the service and at least three monthly, or more frequently to respond to any changing needs. The provision of services is provided to meet the individual needs of the residents. A team approach to care is provided ensuring continuity of services. Referrals to other health and disability services is planned and coordinated, based on the individual needs of the resident. The families interviewed report that care plans are implemented and that the service manages the residents in a manner that is professional and caring.

The service has a planned activities programme to meet the recreational needs of the residents. Residents are encouraged to maintain links with family and the community.

A safe medicine administration system was observed at the time of audit. The service has documented evidence that staff responsible for medicine management are assessed as competent to do so.

Residents' nutritional requirements are met by the service with likes, dislikes and special diets catered for and food available 24 hours a day. The service has a four week, summer/winter rotating menu which is approved by a registered dietitian.

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 are documented emergency management response processes which are understood and implemented by the service providers. This includes protecting residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

The building has a current building warrant of fitness and the service has an approved fire evacuation plan. Medical and electrical equipment is checked to meet legislative requirements.

The facilities meet residents' needs with the provision of appropriate furnishings, single bedrooms, adequate toilet, bathing, hand-washing, and dining and relaxation areas. The service has a long term maintenance plan and ongoing reactive maintenance. Not all wall surfaces can be cleaned to meet infection control standards, which needs improvement.

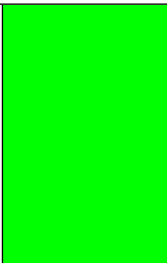
The facility is appropriately heated and ventilated. The outdoor areas provide suitable furnishings and shade for residents' use.

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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At the time of audit there is no restraint or enablers in use. Restraint approval and assessment processes are known to staff. Staff undertake annual education related to restraint minimisation and they have a clear understanding of the difference between enablers and restraints. Restraint would only be used for safety reasons.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme aims to prevent the spread of infection and reduce the risks to residents, staff and visitors. The surveillance programme is appropriate for the size and nature of the services provided. Monthly surveillance data and audits are recorded, collated and reported to management, and quarterly data to the contracted infection control advisory service.

The Infection Control Coordinator (ICC) is suitably qualified for the role and implements and reviews the infection control programme annually.

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	41	0	4	0	0	0
Criteria	0	89	0	4	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff interviewed demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). The Code is included in staff orientation and in the annual in-service education programme, which was sighted. Residents' rights are upheld by staff (e.g., staff knocking on residents' doors prior to entering their rooms, staff speaking to residents with respect and dignity, staff calling residents by their preferred names). Staff observed on the days of the audit demonstrated knowledge of the Code when interacting with residents.</p> <p>The residents and relatives interviewed reported that they are treated with respect and dignity.</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>	FA	<p>Evidence was seen of the consent process for the collection and storage of health information, outings and indemnity, use of photographs for identification, sharing of information with an identified next of kin, and for general care and treatment. The resident's right to withdraw consent and change their mind is noted. Information is provided on enduring power of attorney (EPOA) and ensuring where applicable this is activated.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements. The consent can be reviewed and altered as the resident wishes. The manager discusses information on informed consent with the resident and family on admission. An advance</p>

		<p>directive enables a resident to choose if they would like active medical treatment to prolong life, transfer to the base hospital for on-going treatment or receive 'comfort care'. The files reviewed have signed advance directive forms which meet legislative requirements</p> <p>Family members and residents are actively involved and included in care decisions as evidenced in residents' files reviewed.</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>	FA	<p>Advocacy information is available in brochure format at the entrance to the facility. Residents and their families are aware of their right to have support persons. This was confirmed in interview with residents.</p> <p>Education from the Nationwide Health and Disability Advocacy Service is undertaken annually as part of the in-service education programme. The staff interviewed report knowledge of residents' rights and advocacy service.</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>	FA	<p>Residents reported on interview that they are supported to be able to remain in contact with the community by outings and the walks to local shops and parks. Policy includes procedures to be undertaken to assist residents to access community services and a van is available.</p> <p>There is portable phone which is taken to the residents as required.</p> <p>Evidence in files reviewed shows attendance at DHB for appointments as required.</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>Complaints management is implemented to meet policy requirements. The service has a hard copy complaints register and all complaints are reported to head office electronically. Complaints are a standing agenda item for both management and staff meetings. Complaints information is shared at staff meetings as confirmed in meeting minutes sighted.</p> <p>As confirmed during management, resident and family/whānau interviews, complaints management was explained during the admission process. Staff confirmed that they understood and implemented the complaints process for written and verbal complaints that occur.</p> <p>At the time of audit there is one recently received complaint which is being addressed by the nurse manager to meet policy timeframes.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The policy details that staff will be provided with training on the Code and that residents will be provided with information on entry to the service. Opportunities for discussion and clarification relating to the Code are provided to residents and their families, as confirmed by interview with the manager and registered nurses (RNs). Discussions relating to residents' rights and responsibilities take place formally (in staff meetings and training forums) and informally (e.g., with the resident in their room). Education is held by the Nationwide Health and Disability Advocacy Service annually.</p> <p>Residents are addressed in a respectful manner as was confirmed in interview with residents.</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 privacy and dignity policy details how staff are to ensure the physical and auditory privacy of residents, ensuring the protection of personal property and maintaining the confidentiality of residents' related information. The process for accessing personal health information is detailed.</p> <p>Evidence was seen in files reviewed of the residents' goals which are personalised and reviewed every six months.</p> <p>Staff interviewed report knowledge of residents' rights and understand the principles of dignity and respect.</p> <p>Residents reported on interview they are treated with patience and encouraged to be as independent as possible.</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>	<p>FA</p>	<p>The relevant policy reviewed includes a range of cultural issues/considerations for staff to be aware. The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to Maori residents. A commitment to the Treaty of Waitangi is included. Family/next of kin input and involvement in service delivery/decision making is sought if applicable.</p> <p>There is a Maori resident in the service at the time of audit and the resident reported on interview to be satisfied with the assessment and recognition of any cultural needs. Education was given to staff on the Treaty of Waitangi in 2015 and staff interviewed reported that they understand the principles of the Treaty of Waitangi and attend the education annually. Staff verbalised on interview their knowledge of the Treaty of Waitangi and respect for different cultures.</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>	<p>FA</p>	<p>The manager and the RNs assess the cultural and/or spiritual needs of the resident in consultation with the resident and family as part of the admission process. Specific health needs and food preferences are identified on admission. The care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the Treaty of Waitangi and/or other protocols/guidelines as recognised by the resident.</p> <p>If required, a person acceptable to the resident is sought from the community to provide advice, training and support for the staff to enable the facility to meet the cultural/spiritual needs of the resident.</p> <p>Annual resident satisfaction surveys monitor satisfaction. Residents and their families are satisfied with the services provided as confirmed in interviews with hospital and rest home residents and review of satisfaction surveys.</p> <p>Staff interviewed reported on the need to respect the individual's culture and values.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The employment position description and the Code of Rights define residents' rights relating to discrimination. Staff interviewed verbalise they would report any inappropriate behaviour to the manager. The manager reported she would take formal action as part of the disciplinary procedure if there was an employee breach of conduct. There is no evidence of any behaviour that requires reporting and interviews with residents indicate no concerns.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Evidence is seen of care staff undertaking or completed the National Certificate in the Care of the Elderly Education programme. All staff have an up to date first aid certificates and all staff who administer medication have yearly assessments to determine competency.</p> <p>The manager and RNs attend education sessions run by the hospice and other local organisations. The planned yearly education programme reviewed included sessions that ensures an environment of good practice. The food service cooks have fulfilled the requirements of safe food handling. Residents' satisfaction surveys show evidence that they are satisfied with the meals and food and any concerns are listened to at monthly meetings.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The open disclosure policy is based on the principle that residents and their families have a right to know what has happened to them and to be fully informed. The cultural appropriateness procedure documents that residents and families who do not speak English shall be advised of the availability of an interpreter at the first point of contact with the service.</p> <p>The service promotes an environment that optimises communication and staff education related to appropriate communication methods.</p> <p>Family interviewed confirmed they are kept informed of the resident's status, including any events adversely affecting the resident. Evidence of open disclosure was documented in the residents' files reviewed, on the accident/incident form and in the residents' progress notes.</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>As required to meet policy, Highlands has a personalised business plan which is in line with the direction and objectives of the organising body as identified in the organisation's operating plan and five year strategic plan. The business plan identifies how services are planned to address residents' needs. The plan shows what can be done to maximise strengths and opportunities identified and minimise weakness and threats. Documented annual goals have been reviewed and reported against quarterly by the manager and the nurse manager to head office. This information is presented to the organisation's board of trustees quarterly.</p> <p>The management team consists of the manager who has been in the role for over three years and the nurse manager who has been in the role for 11 months. The nurse manager is a registered nurse with a current practising certificate. Both managers have experience and qualifications related to the roles they undertake and ongoing education is attended. The organisation's quality and risk manager represented the organisation on the days of audit.</p> <p>On the day of audit, there were six rest home level care and 35 hospital level care residents. There are no dedicated rest home or hospital level areas as all bedrooms can be used for either level of care. Management confirmed that residents who enter the facility have one aged care contract for both private and subsidised care.</p> <p>Job descriptions identify management members' experience, education, authority, accountability and responsibility for the provision of services.</p> <p>Interviews with residents and family/whānau confirmed that their needs were met by the service.</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>	FA	<p>During a temporary absence of either manager there is a system in place to ensure their roles are covered by other staff who are qualified to assist when required. Assistance from head office staff is given to ensure the day to day operation of the service remains efficient and effective to meet residents' needs.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>The service has a quality and risk management system which was understood and implemented by service providers. This includes the development and update of policies and procedures at organisational level, regular internal audits, incident and accident reporting, health and safety reporting, restraint, infection control data collection and complaints management. If an issue or deficit is found a corrective action is put in place to address the situation. Information is shared with all staff as confirmed in meeting minutes sighted and verified by staff interviewed. Policies which were outdated when the document review was undertaken prior to the onsite audit had been updated and were sighted on the day of audit.</p> <p>All reporting is linked to management processes via electronic media which is analysed at facility and governance level. At facility level this information is used to inform ongoing planning of services to ensure residents' needs are met. The service recognised that service delivery needed to be improved owing to an overall satisfaction survey rating of 62%. There are various documented quality projects occurring to rectify this. For example, activities are overseen by a contracted occupational therapist and regular internal audits are being conducted which show ratings are increasing related to meeting all residents' needs. The service can also demonstrate a greater family/whānau involvement in decision making related to resident care needs and information sharing.</p> <p>Actual and potential risks are identified and documented in the hazard register and in the quality and risk plan. Newly found hazards are communicated to staff and residents as appropriate. Staff confirmed that they understood and implemented documented hazard identification processes which are taken to the health and safety meeting which is part of the quality meetings.</p> <p>Staff, resident and family/whānau interviews confirmed any concerns they have were addressed by management.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events</p>	PA Low	<p>Management confirmed their understanding of their statutory and regulatory obligations in relation to essential notification including uncontrollable events and any deaths referred to the</p>

<p>are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>coroner.</p> <p>Policy identifies that all accidents, incidents and near misses must be recorded and reported to management accurately and within documented timeframes as identified in the flow chart procedure. For example, serious harm must be notified to management immediately. Staff reporting of incident and accidents included the family/whānau being notified to meet the principles of open disclosure. Incident and accident forms sighted did not always describe the actions taken. In one file reviewed, no incident or accident form could be found that recorded the fall a resident had.</p> <p>Staff interviewed stated they report and record incidents and accidents and that this information was shared at all levels of the organisation. Management confirmed during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated.</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>	<p>PA Low</p>	<p>Policies and procedures identify human resources management that reflects good employment practice and meet the requirements of legislation. Upon employment, referees are checked and job descriptions clearly describe staff responsibilities and best practice standards. Staff complete an orientation programme with specific competencies for their roles. Competencies are repeated annually as required. Staff who require visas to be updated have this managed via head office to ensure they are kept up to date.</p> <p>Staff undertake training and education related to their appointed roles. The education calendar is set at organisational level with alterations made to meet identified needs for Highlands. Staff education includes regular on site education with guest speakers, off-site seminars and training days and on line topics to ensure all aspects of service provision are met. This was confirmed in the education records sighted for 2014-2015. Annual appraisals are overdue in three of the six staff files reviewed.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and annually, as confirmed in documentation sighted. Resident and family/whānau members interviewed stated that residents' needs are met by the service.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled</p>	<p>FA</p>	<p>Organisational policy identifies that at all times, adequate numbers of suitably qualified staff are on duty to provide safe quality care. Rosters are analysed at head office to ensure staffing numbers match residents' level of care needs. The service has five serviced apartments approved for rest home care but to date these have not been used. They ensure that staffing</p>

<p>and/or experienced service providers.</p>		<p>numbers allow for one caregiver to assist the night porter should anyone need to assist with a village resident. For example, there are three staff rostered, seven nights a week.</p> <p>A review of rosters shows that staff are replaced when on annual leave or sick leave. Staff interviewed confirmed there are adequate staff on each shift and that they have time to complete all tasks to meet residents' needs. Residents interviewed stated all their needs have been met in a timely manner.</p> <p>There is a registered nurse on duty at all times. The activities coordinator works Monday to Friday and there are dedicated kitchen, laundry and cleaning staff seven days a week. There is a night porter who works seven nights a week from 9.30pm to 6.30am who responds to any village call bells to ensure there are always two staff on the floor in the care unit.</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>	<p>FA</p>	<p>Information is entered into the resident information management system in an accurate and timely manner. The resident's administration details are recorded on the day of admission and updated as information changes. The residents' files reviewed were accurate and up to date. Archived records are stored on site in a secure cupboard. The records are filed in an orderly manner and are easily retrievable. Current resident information is not publicly accessible or observable. Residents' current files are stored in the staff office which is only accessible by staff. All residents' files reviewed were legible and the name and designation of the staff member was identifiable. The service keeps a signature verification record for all staff.</p> <p>Residents' information and file is stored securely and was not on public display. Files are integrated and available for all health providers. The resident's name and date of birth and national health index (NHI) are used as the unique identifier on all residents' information sighted.</p> <p>All resident information required is completed as sighted in residents' files reviewed.</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>	<p>PA Low</p>	<p>An information brochure is available for families who make enquiries about the facility. There is no evidence that the information brochure has being given to families on enquiry.</p>
<p>Standard 1.3.10: Transition, Exit,</p>	<p>FA</p>	<p>There is a specific transfer form to document information involving the resident being transferred to the DHB. The form highlights any known risks, such as falls, includes current</p>

<p>Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>medications, current information related to the national health index number (NHI), date of birth (DOB), next of kin, instruction regarding specific treatments and may include a medical referral as appropriate.</p> <p>When the resident is transferring to another facility another form is used outlining activities of daily living, reason for transfer, current medical problems, past history, medications, current treatments and observations. A verbal handover is given by the manager or RN on duty. Communication is maintained with the family as confirmed on interview.</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>	FA	<p>The medication records reviewed were dated, signed off and signatures can be verified with the specimen signature list. Photo-identification was observed on each record sighted. Allergies and sensitivity were documented on signing sheets. There was evidence that signing sheets are recorded appropriately and alert stickers are available. Signature specimen lists were in the front of each medication folder for the medical and nursing staff for verification if required.</p> <p>There were no residents self-medicating at the time of the audit. There are standing orders which are signed and reviewed annually. The staff responsible for medication management have all completed medication competencies and on-going education relating to medication management as verified on the education record spreadsheet reviewed.</p> <p>The service implements reconciliation processes which include the checking of all blister packs for accuracy by the RNs when delivered to the facility and all medication charts are faxed to the pharmacy and checked against the medical review updates every three months. There are processes in place to rotate the stored medicines to ensure they do not expire.</p> <p>The GP conducts medicine reconciliation when residents are admitted to the service and at least three monthly thereafter. Medicine file reviews show that each medication is individually signed.</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>Food monitoring of all the fridges and freezers occurs on a daily basis and the records reviewed show that temperatures are within the required range. All equipment and resources are readily available, inclusive of personal protective items, such as gloves, hats and aprons. The kitchen is large and areas are designated for food preparation, plating/tray system serving areas, clean and dirty areas as required. The kitchen was very clean on the days of audit. Daily cleaning schedules are met by the staff in all areas of the food service, as was observed. Rubbish was stored appropriately and disposal processes are in place. A waste</p>

		<p>management protocol is followed.</p> <p>On admission a nutritional assessment is performed by the RN and a copy is provided and retained by the kitchen manager. Any special dietary requirements or special diets are recorded and acknowledged by the kitchen staff when preparing the individual meals. Birthday cakes are made when clients celebrate this occasion.</p> <p>Evidence of menu reviews being undertaken by a registered dietary service contracted to provide advice and support is completed. Changes suggested by the dietitian are implemented as part of the quality programme.</p> <p>There are two qualified chefs who oversee all aspects of the kitchen management and kitchen hands. Staffing is consistent over seven days and evidence was seen of safe food handling certificates.</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 manager reported that the needs assessment team at the DHB usually ring and a telephone discussion verifies the suitability for admission before the family visits, if the resident is in hospital. There is a folder which contains documentation of all enquiries and the action taken if the admission is declined. This included contacting the referral agency.</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>The initial nursing assessment includes good use of clinical tools, including falls risk, pressure area risk and pain assessment. Referral letters are sighted from external agencies, including DHB clinics, and there is evidence of family involvement in the assessment process. Evidence was sighted in files reviewed that assessments are conducted within the specified timeframes. The assessment information is used as part of care plan development.</p> <p>The RNs reported that they oversee all care plans and residents and family are included.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>In files reviewed evidence was sighted of interventions related to the desired outcomes or each resident. Risks identified on admission are included in the care plan and these include falls risk, pressure area risk and pain management.</p> <p>All health professionals document in the resident's individual clinical file and have access to care plans and progress notes as part of the integrated file system. Documentation in files</p>

		<p>reviewed included nursing notes, medical reviews and hospital correspondence. The residents reported that they are included in the care planning and are aware of any changes and these are discussed with them. Care staff reported they are informed of any changes to care plans at shift changeover.</p> <p>The RN accompanies the doctor on rounds and the doctor writes notes in the files. The care plan is written in a language that is user friendly and able to be understood by all staff. In residents' files reviewed there was evidence of family involvement in care planning.</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>There is documented evidence that the interventions relating to the residents' assessed needs and desired outcomes are evaluated as required and within timeframes to ensure residents' planned outcomes are being met. There was evidence in documentation reviewed of a resident whose falls risk assessment had changed from a low to medium risk. Changes to the care plans included regular checking of the resident, leaving the resident's bell accessible and use of a sensor mat.</p> <p>The clinical staff interviewed reported they were informed of any care plan changes at hand over and have relevant in-service education as required specific to any new interventions.</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>	FA	<p>There is one activities coordinator and a volunteer who implements the activity programme. A qualified occupational therapist oversees all aspects of the programme and visits fortnightly to meet with staff and review paperwork. A plan is in place for the activity coordinator to commence diversional therapy training in 2016 through NZQA.</p> <p>Evidence is seen of monthly resident meetings, resident satisfaction surveys and follow up on all concerns and suggestions. A quality initiative is in place to ensure the ongoing activity programme is maintained and resident satisfaction surveys improve.</p> <p>Evidence is seen on the programme of music, entertainment, exercise groups and outings to local parks. Community involvement includes schools and early childhood visits.</p> <p>Staff interviewed ensure that an activity is available when regular staff are not available.</p>
Standard 1.3.8: Evaluation	FA	<p>Reviews and ongoing assessments of residents were clearly documented in the residents' files reviewed. The medical consultations were clearly documented on the medical clinical</p>

<p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>		<p>records sighted. Documentation demonstrated that the care and support plans are evaluated at least six monthly or more often if required. If a resident is not responding appropriately to the interventions being delivered, or their health status changes, then this is discussed with the GP.</p> <p>Residents' changing needs are clearly described in the care and support plans reviewed. Short term care and support plans are available and were sighted for wound care management, skin tears, pain management, changes in mobility, changes in food and fluid intake requirements, weight loss and skin cares.</p> <p>The multidisciplinary (MDT) reviews are organised by the RN and families are invited to attend or contribute to the review process. Family and residents confirmed their input into the MDT meeting. Family members reported that they can consult with the staff at any time if they have concerns or if there is a change in the resident's condition. The GP, nursing staff and activities coordinator contribute to the reviews.</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>The policy related to exit, transfer or transition states that residents will have access to appropriate external treatment and support services and will be referred in a timely fashion. All referrals are clearly documented in the progress notes and in the diary. The family are notified of the upcoming appointment and are invited to attend and assist.</p> <p>In residents' files reviewed information relating to the referral process was sighted as was appropriate. Residents are given a choice of GP when they are admitted. If the need for other services are indicated or requested, the GP or RN sends a referral to seek specialist assistance from the DHB. The resident and the family are kept informed of the referral process.</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>Policy and procedures sighted encourage the careful handling of all waste to reduce the potential for injury or illness associated with handling and transport of all waste and hazardous substances.</p> <p>All chemicals were seen to be securely stored and clearly labelled. Personal protective equipment/clothing (PPE) sighted included disposable gloves and aprons and goggles. Staff interviewed confirmed they can access PPE at any time. One staff member said that sometimes gloves run short. This was discussed with management who confirmed there are always gloves available but sometimes a box of gloves in one area may be empty. Staff can access the gloves for another area of the facility. Staff were observed wearing disposal gloves</p>

		<p>and aprons as required.</p> <p>Interviews with residents and family/whānau members confirmed the environment was suitable to meet their needs.</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>	PA Low	<p>Documentation sighted identified that all processes are undertaken as required to maintain the building warrant of fitness. The current warrant of fitness expires 9 March 2016. The maintenance plan is overseen by the manager. There is an established reactive maintenance process in place to manage maintenance issues as they arise. There are wall areas in one lounge, the doctors' clinic and a bathroom which cannot be adequately cleaned to ensure infection control standards can be maintained.</p> <p>Electrical safety testing occurs to meet legislative requirements and medical equipment is checked by an approved provider.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring the flooring is secure, bathroom floors are non-slip, the equipment supplied to residents to assist with mobility is in good order, and walking areas are not cluttered. The service provides resident equipment to meet DHB contractual requirements of section D15.3. Regular environmental audits sighted identify that the service actively works to maintain a safe environment for staff and residents.</p> <p>Residents are able to access shaded outdoor areas via a lift. Resident bedrooms all have a small outdoor balcony.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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>	FA	<p>There are adequate toilet/shower facilities for residents with separate staff and visitor facilities. All bedrooms have a hand basin, 14 bedrooms have ensuite toilet and one bedroom has full ensuite facilities. Hot water temperatures are monitored and documentation identified that they remained within safe levels.</p> <p>(Refer comments in Standard 1.4.2.4 related to one part of the north-west bathroom wall not being sealed).</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate</p>	FA	<p>All bedrooms are single occupancy and of a size which allows enough space for residents to mobilise with or without assistance in a safe manner. They are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal</p>

<p>personal space/bed areas appropriate to the consumer group and setting.</p>		<p>belongings.</p> <p>Resident and family/whānau members interviewed confirmed they were happy with their bedroom areas.</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>	<p>FA</p>	<p>Residents are provided with safe, adequate areas to meet their relaxation, activity and dining needs. There are two lounge areas, and one dining area. Areas contained comfortable furnishings to meet residents' needs. Residents and family/whānau voiced their satisfaction with the environment. Activities are undertaken in both lounge areas. The smaller of the two lounges has a hole in the wall where a heater has been replaced and the wall lining by the window is peeling. (Refer comment in Standard 3.1.9).</p> <p>Residents are happy with the lounge areas provided.</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>	<p>FA</p>	<p>Chemicals are securely stored and appropriately labelled. Dedicated cleaning and laundry staff maintain a documented daily cleaning schedule. The facility looks and smells clean.</p> <p>The washing machines are serviced regularly and washing cycles are checked by the chemical providers. Laundry staff understand what each wash cycle is for.</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>	<p>FA</p>	<p>Emergency management policies and procedures implemented guide staff actions in the event of various emergency events. Emergency supplies and equipment include food and water should they be required. The emergency evacuation plan in place has been approved by the fire service. Fire equipment is checked annually by an approved provider. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and gas BBQs for cooking.</p> <p>Emergency education and training for staff includes six monthly trial evacuations. All resident areas have smoke alarms and a sprinkler system which is connected to the fire service. There is a staff member who holds current first aid on each shift (35 staff hold current first aid certificates).</p> <p>Staff are required to ensure doors and windows are securely closed at night. There is a night porter who undertakes regular security checks of the inside and outside of the facility seven days a week. There is adequate outdoor lighting. Staff and residents interviewed confirmed</p>

		<p>they feel safe at all times.</p> <p>Call bells are located in all residents' bedrooms and response times are monitored at least monthly by the nurse manager. Resident and family/whānau interviewed confirmed call bells were answered in an acceptable timeframe.</p>
<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>Resident areas have at least one opening window to provide natural light and for ventilation. An even temperature is maintained throughout the facility and ventilation occurs by opening of doors and windows. The facility was warm and well aired on the days of audit. Resident and family/whānau interviewed stated the facility is kept at a suitable temperature throughout the year.</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 service has a documented infection control programme which is reviewed as part of the annual quality review programme. The infection control programme minimises the risk of infections to residents, staff and anyone else visiting the facility.</p> <p>The infection control coordinator (IPCC) is a RN. The infection control coordinator monitors for infections, uses standardised definitions to identify infections, surveillance, changes in behaviours, monitoring of organisms related to antibiotic use and the monthly surveillance record. Infection control is a standing agenda item in the staff meetings. If there is an infectious outbreak this is reported immediately to staff, management, and where required, to the DHB and public health department.</p> <p>The infection control coordinator interviewed reported that the staff have good assessment skills in the early identification of suspected infections. Residents with infections are reported to staff at handover, have short term care plans and documentation in the progress notes.</p> <p>A process is identified in policy for the prevention of exposing providers, residents and visitors from infections. Staff and visitors suffering from infectious diseases are advised not to enter the facility by notices at entrances. When outbreaks are identified in the community, notices are placed at the entrance not to visit the service if the visitor has come in contact with people or services that have outbreaks identified. Sanitising hand gel is available throughout the facility and there are adequate hand washing facilities for staff, visitors and residents. Residents suffering from infections are encouraged to stay in their rooms if required, though the infection control coordinator reports that this can be difficult at times with residents with cognitive impairment.</p> <p>The RN and caregivers interviewed demonstrated good infection prevention and control</p>

		<p>techniques and awareness of standard precautions, such as hand washing.</p> <p>A lounge and bathroom area are not being able to be cleaned properly to ensure infection control standards are maintained. Refer comments in criterion 1.4.2.4.</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>The IPCC confirmed being responsible for facilitating infection prevention and control activities. The IPCC has attended relevant education on infection prevention and control. The IPCC advises she liaises with the GP if there are any concerns about a resident with a known or suspected infection.</p> <p>The IPCC is responsible for gaining infection control, infectious disease and microbiological advice and support, where this is not available within the organisation. In the event of an outbreak advice will be sought from the GP, gerontology nurse specialist at the DHB or laboratory services.</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>The infection control manual contains the policies and procedures required to meet this standard.</p> <p>A copy of the infection prevention and control policies are available for staff to refer to as and when required and this was sighted. Staff interviewed confirmed access to policies on infection prevention and control. Staff reported if they had any concerns they would contact the RN who is on call when not on site. The GP confirmed in interview that he is contacted by staff in a timely manner when the needs of the resident have changed.</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>Evidence:</p> <p>Education is provided for staff on infection prevention and control as a component of the orientation and ongoing education programme. In addition, newsletters issued by an external infection control company and DHB include infection prevention and control topics. As an example a newsletter received was on urinary tract infections. This information was disseminated to staff.</p> <p>Residents and family are provided with advice on infection prevention and control activities via residents' meetings. The residents' meeting minutes included discussion on the importance</p>

		<p>of hand hygiene.</p> <p>Staff reported on interview they regularly receive education on infection prevention as part of the annual programme and also at handover if a situation arises.</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 for infections is carried out in accordance with agreed objectives, priorities, and the methodology that is specified in the infection control programme. The surveillance programme reviewed is appropriate for the size and nature of the services provided.</p> <p>The infection control coordinator (ICC) is a RN with experience and knowledge in infection prevention and control. The ICC/RN explained the surveillance system, the role of ICC, responsibilities and the reporting systems in place. Information gained is reported as part of the quality management system requirements and quality improvement objectives on a monthly basis. The ICC and the GP interviewed are aware of any reporting obligations and who to contact.</p> <p>Relevant types of infections, such as urinary tract infections, lower respiratory infections, influenza, chest, skin and wound infections, oral infections, shingles and other infections are part of the surveillance programme. Surveillance forms have been developed and implemented for this purpose. Infection reports are completed and reviewed individually by the ICC. Any immediate trends, advice or information fact sheets are provided back to the service concerned. Additional advice and support on infection control matters can be sought from the microbiologist at the DHB or a private infection control nurse consultant.</p> <p>Caregivers reported that they are kept well informed and understood their responsibilities for reporting any signs and symptoms of a resident having an infection to the RN.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint minimisation policy reflects the requirements of the restraint minimisation and safe practice standard. It states that the service aims to minimise the use of restraint and to ensure that if restraint is necessary, to keep the resident safe from harm. The use of enablers are voluntary and the least restrictive option to meet the needs of the resident. Policy contains all necessary documentation related to the use of restraint.</p> <p>The service had no restraints or enablers in use at the time of audit. Clinical staff undertake an annual competency related to the safe and correct use of restraint should it be required. Staff verbalised their understanding and knowledge related to restraint and enabler use during interview.</p>

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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	<p>Staff confirmed they document all adverse events using specific incident and accident forms. Management confirmed that incident and accident information is used to identify opportunities to improve service delivery and to manage risk. This is not always identified on the incident forms sighted. For example, policy requires neuro-observations to be undertaken following any fall with a head injury. No evidence of recordings were shown on the incident and accident forms sighted. One resident whose file identified they had a fall did not have a corresponding incident and accident form.</p>	<p>Incident and accident reporting does not always show what follow up actions are taken. Staff state they are doing this but no documented evidence could be found in one of two files reviewed for residents who had a head injury. One file had no corresponding incident or accident form that could be located for a fall shown in the resident's progress notes.</p>	<p>Ensure all adverse events are correctly reported and that the forms are completed to identify and include any shortfalls and meet best practice standards by managing all risk factors.</p>

				180 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 system in place which identifies education planning relevant to aged care provision. Staff were observed providing care services in a safe manner. All caregivers have either completed or are working towards a recognised aged care education.</p>	<p>Staff education is planned and recorded by the service. Staff are supported and encouraged to attend ongoing recognised aged care education. Compulsory education session attendance is monitored by management. Annual appraisals are used as a tool for staff to identify ongoing educational needs. In three of six staff files reviewed the annual appraisals were not up to date. This does not meet the DHB contractual requirements found in section D17.7f.</p>	<p>Ensure all staff annual appraisals are up to date to meet DHB contractual requirements.</p> <p>180 days</p>
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	<p>An information brochure is available to be given to families on enquiry about the service. A folder is available to ensure all enquiry forms are completed and followed up as part of the admission process. An information brochure is available but this has not been given out to families who enquire at the facility.</p>	<p>An information brochure is available but there is no evidence that this is given out to families or residents upon enquiry to service. Three residents and families reported on interview that no written information was given on enquiry.</p>	<p>Ensure up to date and relevant information is available for all residents and families on enquiry.</p> <p>180 days</p>
<p>Criterion 1.4.2.4</p> <p>The physical environment minimises risk of harm, promotes</p>	PA Low	<p>The environment minimises risk related mobility by having secure flooring and wide corridor which allow residents to move around safely. The walls in one of the lounge areas has several holes in it and in one area the wall lining is peeling off, the wood behind the hand basin in the doctors'</p>	<p>One lounge area, the wall behind the hand basin in the doctors' clinic and one bathroom wall (north-west bathroom) is exposed to water. The means these areas cannot be</p>	<p>Ensure maintenance is undertaken to ensure all areas can be</p>

<p>safe mobility, aids independence and is appropriate to the needs of the consumer/group.</p>		<p>clinic has paint peeling off leaving the wood fully exposed and one bathroom area has exposed wall board which is being warped owing to water damage. This means that not all areas are able to be cleaned in a manner to meet infection control standards. With the exception of the bathroom wall, the other issues have been identified in the maintenance book and the manager is aware.</p>	<p>adequately cleaned to ensure infection control standards are maintained.</p>	<p>cleaned to maintain all infection control standards of cleaning.</p> <p>180 days</p>
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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.