

Heritage Lifecare Limited - George Manning House

Introduction

This report records the results of a Provisional 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:	Heritage Lifecare Limited
Premises audited:	George Manning House
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 29 November 2016 End date: 30 November 2016
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:	63

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

General overview of the audit

George Manning House in Sydenham Christchurch is certified to provide rest home and hospital level care for 81 residents. On the day of this provisional audit there were 63 residents. This consisted of 16 rest home residents and 47 hospital residents. There are 34 units on the property which can be occupied under a purchased occupational right agreement and were not part of this audit.

This provisional audit against the Health and Disability Services Standards and the provider's contract with the district health board (DHB), included observation of the environment, interviews with the management team and staff, review of documentation and interviews with residents and their families and a general practitioner. The audit was attended by a representative for the prospective purchaser.

Two areas requiring improvement were identified during the audit, relating to quality audits and general maintenance.

Consumer rights

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect the choices, personal privacy, independence, individual needs and dignity of residents. Staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Māori health plan and related policies guide care. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health care providers, which contributes to ensuring services provided to residents are of an appropriate standard.

There is a complaints process that is understood by residents, family members and staff and meets the requirements of the Code of Health and Disability Services Consumers' Rights. The manager maintains a current register.

Organisational management

The organisation has a documented business and strategic plan in place which is reviewed regularly. The governing body is George Manning House Management Limited. A manager and clinical supervisor oversee the day to day management of the facility. They both have position descriptions and the necessary skills, knowledge and experience to perform their job.

There is a quality and risk management system in place. This includes quality and clinical indicators, an internal audit programme and management of risks. A suite of policies and procedures are current and reviewed regularly. The adverse events reporting system and corrective action planning link to the quality improvement cycle to manage any risks and ensures quality improvement occurs.

There are appropriate systems for the recruitment, appointment and management of all staff. Formal orientation and an ongoing education and training plan is provided/developed for all employees. Staff have a current performance appraisal and this occurs annually. The clinical supervisor prepares the roster based on residents' needs, and safe staffing levels. The roster includes registered nurses, caregivers, and a range of laundry, cleaning, kitchen and activities staff. The current roster is adequate for the number of residents and their level of need.

The prospective purchaser has no immediate plans to change the management structure at the facility or organisational management systems. Their representative was interviewed on site. They operate other facilities that are certified under these standards and understand the requirements. There is a documented transitional plan, which will be implemented once the sale is confirmed.

A resident information management system is in place and information is entered in a timely and accurate manner. Information of a private or personal nature is maintained in a secure manner that is not publicly accessible or observable.

Continuum of service delivery

The organisation works closely with the local Needs Assessment and Service Co-ordination Service (NASC), to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate the admission.

Residents' needs are assessed by the multidisciplinary team on admission, within the required timeframes. Registered nurses are on duty 24 hours each day in the facility and are supported by care and allied health staff and designated general practitioners. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised, based on a comprehensive and integrated range of clinical information. Short term care plans are developed to manage any new problems that might arise. All residents' files reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Residents and families interviewed reported being well informed and involved in care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

The planned activity programme, overseen by a trained diversional therapist, provides residents with a variety of individual and group activities and maintains their links with the community. A facility van is available for outings.

Medicines are managed according to policies and procedures based on current good practice and consistently implemented using a manual system. Medications are administered by registered nurses and care staff, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Policies and procedures guide food service delivery, supported by staff with food safety qualifications. The kitchen was well organised, clean and meets food safety standards. Residents verified satisfaction with meals.

Safe and appropriate environment

The facility is purpose built and well maintained. Residents' rooms are kept clean, tidy, well ventilated and at a comfortable temperature. There are a number of communal areas which provide a variety of spaces for residents to use. There are enough toilets and bathrooms for the number of residents.

Easily accessed, safe and attractive outside areas are provided for use for residents. The building has a current building warrant of fitness.

There are systems in place for the management of waste and hazardous substances by staff who have been trained in this area.

Emergency procedures are documented and available in several places around the facility. Regular fire drills occur and staff are well trained to respond in any emergency. There are two generators available and adequate supplies for civil defence and other emergencies. Appropriate security arrangements are in place.

There is a plan in place to demolish and rebuild an earthquake damaged wing, and this will continue if the facility is sold. Other than the rebuild, the prospective provider has no plans to make any other structural alterations to the environment that will impact on certification of the facility.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit, the service had seven residents using restraint in the form of bedrails and/or lap belts and two residents with bedrails as an enabler.

Infection prevention and control

The infection prevention and control programme, led by an appropriately trained infection control coordinator, aims to prevent and manage infections. There are terms of reference for the infection control committee which meets monthly. Specialist infection prevention and control advice is accessed from the district health board (DHB), microbiologist, infectious diseases physician, and group clinical advisory committee. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended, benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

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	48	0	2	0	0	0
Criteria	0	99	0	2	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>George Manning House has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options to residents and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records.</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>Registered nurses and care staff interviewed understand the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form including for photographs, outings, invasive procedures.</p> <p>Advance care planning, establishing and documenting enduring power</p>

		<p>of attorney requirements and processes for residents unable to consent is defined and documented where relevant in the resident's record. Staff demonstrated their understanding by being able to explain situations when this may occur.</p> <p>Staff were observed to gain consent for day to day care on an ongoing basis.</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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters related to the Advocacy Service were also displayed in the facility, and additional brochures were available at reception. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons.</p> <p>Staff are aware of how to access the Advocacy Service and examples of their involvement were discussed at staff interviews.</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 are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment. The facility supports the philosophy of Quality of Life, caring and living life to the highest level of independence.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family/whānau and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</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>There is a complaints policy which aligns with Right 10 of the Code. The manager leads the investigation of complaints with input from the clinical supervisor for clinical issues. Complaints forms are visible and available at the front reception. A complaints procedure is provided to residents within the information pack at entry. Five complaints in 2015 and one in 2016 were included on the register. All have been resolved</p>

		to the satisfaction of the complainant. The complaints register is up to date.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Residents interviewed report being made aware of the Code and the Nationwide Health and Disability Advocacy service (Advocacy Service) through facility manager as part of admission process, information provided, to resident and family/whanau and discussion with staff. The Code is displayed in the rest home and hospital entrance way, in front of the office and nurses' stations. Interview with the representative for the potential purchaser confirmed their understanding of consumer's rights during service delivery. That 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, facilitates informed choice, minimises harm, and acknowledges cultural and individual values and beliefs.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices. Staff understood the need to maintain privacy and were observed doing so throughout the audit while attending to personal cares, ensuring resident information is held securely and privately, exchanging verbal information with residents and their family/whanau. All residents have a private room and ensuite. Residents are encouraged to maintain their independence by staff ensuring individual care plans are followed, attending community activities, arranging their own visits to the doctor, participation in clubs of their choosing. Each plan included documentation related to the resident's abilities, and strategies to maximise independence. Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Staff understood the service's policy on abuse and neglect, including

		what to do should there be any signs. Education on abuse and neglect is part of the orientation programme for staff, and is then provided on an annual basis, as confirmed in staff and training records.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whanau to Māori residents. There is a current Māori health plan developed with input from cultural advisers. Current access to resources includes the contact details of local cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respect these. Resident's personal preferences, required interventions and special needs were included in all care plans reviewed. Residents had dietary preferences and spiritual preferences documented, interviews confirmed that staff ensure the residents' needs are met. A resident satisfaction questionnaire includes evaluation of how well residents' cultural needs are met and this supports that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. A general practitioner interviewed also expressed satisfaction with the standard of services provided to residents. The induction process for staff includes education related to professional boundaries and expected behaviours. All registered nurses have records of completion of the required training on professional boundaries. Staff are provided with a Code of Conduct in both the staff orientation booklet and their individual employment contract. Ongoing education is also provided on an annual basis, which was confirmed in staff training records. Staff are guided by policies and procedures and, when interviewed, demonstrated a clear understanding of what would</p>

		constitute inappropriate behaviour and the processes they would follow should they suspect this was occurring.
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through evidence based policies, input from external specialist services and allied health professionals, for example, hospice/palliative care team, diabetes nurse specialist, physiotherapist, occupational therapist, wound care specialist, community dieticians, a psycho-geriatrician and mental health services for older persons, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for internal and external education through Careerforce training and there is evidence of a compulsory plan for all staff where staff are booked to attend education to support contemporary good practice.</p> <p>Other examples of good practice observed during the audit included extra fluid rounds, prompt answering of call bells, regular toileting rounds, and pressure injury prevention strategies.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. There was also evidence of resident/family/whanau input into the care planning process. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Interpreter services can be accessed via the DHB or Older Persons Health when required. Staff knew how to do so, although reported this was rarely required due to all residents able to speak English. Staff able to provide interpretation as and when needed and the use of family members, and communication cards are available for any</p>

		potential residents for whom English is not their first language.
<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>	FA	<p>George Manning House Management Limited is privately owned by a couple who are the only two directors of the company. One owner has assumed the role of manger in the past year. She attends all meetings.</p> <p>The mission, vision and values of the organisation are documented in the strategic plan and quality plan. These are reviewed annually when progress against the objectives and goals in these documents are reviewed.</p> <p>An interview with a representative of the prospective owner occurred (the quality and compliance manager). The prospective owners have a documented transition plan, which includes an organisational structure at senior management and executive level. If the proposed sale becomes unconditional and progresses they will not make any immediate changes to the organisation's management. Instead they will provide support and oversight and replace the management reporting with their own systems and monitoring. A transition manager, employed by the current owner/manager will commence immediately and work for at least three months through the transition process with the potential new owners. This person is a registered nurse with a current practising certificate. They are an experienced facility manager and will take over the management of the facility until Heritage Lifecare Limited are the confirmed new owners and are in a position to appoint a permanent facility manager. This is a full time position.</p> <p>The prospective owners Heritage Lifecare Limited (HLL) provide age related services and management services in multiple other locations in New Zealand. They understand the requirements of the Health and Disability Services sector standards and the contracts for the provision of age related care with a wide range of District Health Boards. The prospective provider has notified the funder of the proposed purchase, and demonstrated they have an understanding of the different certified service types and the residential care services agreement. They have also approved the appointment of the transition manager.</p>

<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>In the absence of the manager the clinical supervisor assumes the role with assistance from the quality assurance team leader. Both have suitable experience for the roles. When this occurs one of the charge nurses takes over some of the clinical supervisor's responsibilities to enable her to undertake the management role.</p> <p>At interview with staff members they report that the manager, quality team leader and clinical supervisor are providing stability as the management team of the facility and their respective areas of responsibility. Staff report that they are approachable with an open-door philosophy.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>There is a comprehensive quality and risk management plan for the facility, which is reviewed annually.</p> <p>The manager and quality team leader coordinate the development and review of all policies and procedures for the facility, and includes these changes as agenda items in all meetings. All documents reviewed during the audit were current.</p> <p>The quality assurance team leader and quality manager coordinate and facilitate the quality committee, which meets every two months through the year. A set agenda includes the quality plan objectives, completed audits for the past two months, adverse events, corrective actions, a report from health and safety, infection control and restraint minimisation committees, as well as any ongoing developments and review of documents.</p> <p>The quality team leader and quality manager implement the internal audit calendar, or delegates them to staff to complete, however there is confusion around responsibilities and audit gaps have emerged.</p> <p>Each month an analyses of quality data is collated and graphs of the adverse events are on display in the staff room. Staff members interviewed confirmed that they receive information about the events, which occur in the facility and how these are managed. They also demonstrated an understanding of their responsibilities in the quality system appropriate to their role.</p>

		<p>There is a risk management plan, which identifies the risks to the business and includes strategies to mitigate these. This is reviewed regularly at the same time as the review of the quality plan and strategic plan. A corrective action plan is in place for any shortfalls.</p> <p>The prospective owner's representative confirmed that their transition plan includes a gradual change over of documentation over time, rather than an immediate and sudden change. They have their own quality plan and audit tools, which they will introduce in line with their transition plan and management reporting and monitoring systems.</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 incident and accident policy includes the essential notifications and statutory and regulatory reporting, including the requirement to report pressure injuries of category 3 under section 31 of the Health and Disability Services (Safety) Act). At interview, the manager demonstrated clearly her responsibility in this area and explained the process when a norovirus outbreak occurred recently.</p> <p>Adverse events are reported and recorded on appropriate event reporting forms. The data from collated adverse events is summarised by the quality manager monthly and reported at meetings and in graph form on the staff room notice board. Staff confirmed that they report events using the reporting forms, or verbally to the quality assurance team leader. They understand the importance of reporting and recording events.</p> <p>General practitioners (GPs) are notified of adverse events when they occur and this was confirmed during interview with one GP who visits, and when reviewing event forms. Residents and family members report that they are also notified of events and appreciate receiving this information. There are no legislative compliance issues that could affect the service.</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</p>	FA	<p>Policies and procedures for recruitment, appointment and management of staff reflect current legislation and good employment practice. All recruitment is managed by the manager with the assistance of the quality assurance team leader. Both were interviewed during the audit.</p>

<p>requirements of legislation.</p>		<p>All appropriate checks are undertaken during the appointment process and confirmed during a review of personnel files. Professional qualifications are verified and monitored annually. Records reviewed verify current practicing certificates / professional registrations for registered nurses, medical practitioners and allied health professionals. Personnel file reviews confirmed that performance appraisals are also current.</p> <p>A comprehensive training and education programme is available for all staff. This includes an orientation and induction programme, ongoing annual training. The quality assurance team leader maintains a training register, which includes essential training, competencies, and other in-service and external training attended by staff. The programme includes wound and pressure injury management.</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>	<p>FA</p>	<p>A staffing policy is in place that is reflective of the roster skill and mix levels to meet the needs of residents in the facility. Rosters are the responsibility of the clinical supervisor. Three weeks of rosters reviewed verified a registered nurse (RN) on every shift with a varying number of resident care assistants (RCA) throughout the facility and across all shifts over 24 hours and seven days a week.</p> <p>There are two cooks and several kitchen hands, two laundry and separate cleaning staff seven days a week. There are two full time activities persons five days a week. A maintenance person and separate gardener complete the compliment of staff at the facility. The clinical supervisor is additional to the RN compliment on any given shift, five days of the week. She is also available on call to the nursing staff outside of these times. The current staffing levels meet the requirements of residents.</p> <p>Residents, family, staff and the GP interviewed reported that there are sufficient numbers of suitably skilled staff at George Manning House.</p> <p>The prospective owner uses a staffing model, and electronic tool, based on the 'Indicators for Safe Staffing'. This can be used as a rostering tool or to inform the development of rosters. As noted, the sale is still conditional at the time of the audit and submission of this report. If the sale proceeds then there will be a transition to their own</p>

		staffing model. The HLL staffing model will maintain safe staffing levels to meet the needs of residents at George Manning House. It will be flexible to the changing acuity needs of the resident population over time.
<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>	FA	<p>The resident's name, date of birth and National Health Index (NHI) number are used on labels as the unique identifier on all residents' information sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and meet with facility manager (FM) and clinical manager (CM). They are also provided with written information about the service and the admission process. The service operates a waiting list for entry. The organisation seeks updates information from NASC and the GPs for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements.</p>

<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge, or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family. At the time of transition between services, appropriate information, including medication records, 24 hours of medication, 24 hours of progress notes, wound charts (where applicable), and advance directives are provided for the ongoing management of the resident. A checklist ensures this occurs. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility, showed a planned, co-ordinated transfer to the acute care service and transition back again. Family members of the resident reported being kept well informed during the transfers of their relative.</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>	<p>FA</p>	<p>The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using a blister pack system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. These medications are checked by a registered nurse against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided monthly and on request.</p> <p>Controlled drugs are stored securely in accordance with requirements. Controlled drugs are checked by two staff for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Standing</p>

		<p>orders are rarely used but processes are in place to enable safe administration and appropriate documentation.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three monthly GP review is consistently recorded on the medicine chart.</p> <p>There were two residents who self-administer medications at the time of audit. Appropriate processes were in place to ensure this is managed in a safe manner.</p> <p>Medication errors are reported to the clinical manager and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by the kitchen manager and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The food services manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional</p>

		<p>needs, is available.</p> <p>Evidence of resident satisfaction with meals is verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were observed to be given sufficient time to eat their meal and those requiring assistance had this provided. There is enough staff on duty in the dining rooms at meal times to ensure appropriate assistance is available to residents.</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>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC service is advised to ensure the prospective resident and family are supported to find an appropriate care alternative. If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC service is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed with the Clinical Supervisor. There is a clause in the access agreement related to when a resident's placement can be terminated.</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>Information is documented using validated nursing assessment tools, such as a pain scale, skin integrity, nutritional screening, falls risk, continence assessment, activity assessment and depression scale, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents' files reviewed during the audit had a current interRAI assessment.</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>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Care plans evidence service integration with progress notes, medical and allied health professional's notations clearly written, informative and relevant. Any change in care required is documented and verbally passed on to relevant staff. Residents and</p>

		families/whanau reported participation in the development and ongoing evaluation of care plans.
<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>Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard at George Manning House. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</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>The activities programme is provided by one trained diversional therapist (DT), and two activities assistants who have both nearly completed the diversional therapy training through Careerforce.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated as their needs change, monthly, and as part of the formal six monthly care plan review.</p> <p>The planned monthly activities programme sighted matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Examples included musicians playing music and singing, planned outings, individual outings, volunteers coming to read to residents, and children's groups coming to visit.</p> <p>The activities programme is discussed at the minuted residents' meeting and indicated residents' input is sought and responded to. Resident and family satisfaction surveys demonstrated satisfaction with the programme and that information is used to improve the range of</p>

		activities offered. Residents interviewed confirmed they find the programme encourages them to reach their highest level of independence within the limitations they have.
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment or as residents' needs change. Evaluations are documented by the RN. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans were consistently reviewed for urinary tracts infections (UTIs), falls, infections, any changes in the resident's normal status and progress evaluated as clinically indicated at least weekly and according to the degree of risk noted during the assessment process. Other plans, such as wound management plans were evaluated each time the dressing was changed. Residents and families/whanau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers. All residents have the choice of their own GP. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the physiotherapist, occupational therapist, needs assessor, gerontology clinical nurse specialist, diabetes nurse specialist, wound care specialist, geriatrician, and older persons' mental health. Referrals are followed up on a regular basis by the registered nurse or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</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>There are policies and procedures for the safe and appropriate storage and disposal of waste and hazardous substances. The health and safety manual includes policy around safe storage and handling of chemicals. Waste is appropriately managed. All chemicals sighted were stored securely. Staff interviewed demonstrated knowledge of handling chemicals and were observed using personal protective equipment.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>PA Low</p>	<p>The current building warrant of fitness expires 1 January 2017. There have been no changes to the building since the previous audit; however, there are plans to demolish the west wing due to earthquake damage. Some rooms in the wing, for example the sluice room, have damage but are not in use. An application for a re-build and plans were sighted as submitted to Council on 5 September 2016. The consent has been slow due to the Kaikoura earthquake. The prospective owner confirmed the planned demolition and re-build will go ahead should they purchase the facility.</p> <p>Residents and family members interviewed during this audit reported that they find the environment is maintained to a high standard at all times and it is well presented.</p> <p>There is a regular system for preventative maintenance, relevant testing, and calibration of equipment. This is maintained and current. However, the system for ongoing general repair and maintenance is incomplete and requires improvement. All hazards have been identified in the hazard register including some clearly marked uneven floors following the earthquake.</p> <p>Outside areas, excluding from the west wing, were easily accessed from the facility and were well maintained. The courtyard from the west wing is not utilised.</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</p>	<p>FA</p>	<p>All residents' rooms have a full ensuite. Residents' rooms have hand-washing facilities with soap dispensers and paper towels. There are sufficient communal showers and toilets for residents. Separate visitor</p>

personal hygiene requirements or receiving assistance with personal hygiene requirements.		and staff toilets are available.
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Residents' rooms are spacious enough to allow care to be provided and for the safe use and manoeuvring of mobility aids. Transfer of residents can occur and equipment can be transferred between rooms. Doors have an additional opening to allow beds, stretchers to be moved through. Mobility aids can be managed in communal rooms.</p> <p>Rooms were observed to be personalised with furnishings, photos and other items and the service encourages residents to bring in personal items.</p> <p>There was room to store mobility aids such as walking frames safely in a separate alcove.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The facility has several communal lounge/dining areas. There are smaller seating areas for residents and families within the facility. Furniture in all areas is arranged to allow residents to freely mobilise. Residents and families interviewed verify that the service is spacious and residents may stay in their own areas use any of the communal lounges.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>All laundry is completed on site in a large laundry. A survey of residents and family confirmed satisfaction with cleaning and laundry services. The service has secure cupboards for the storage of cleaning chemicals. All chemicals sighted were labelled. Material safety datasheets are displayed. Cleaning processes are monitored for effectiveness and compliance with the service policies and procedures. Cleaning staff have completed chemical safety training.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	<p>There is at least one staff member on duty at all times with a first aid certificate. Emergency plans are accessible to staff and includes management of all potential emergency situations. The organisation</p>

<p>emergency and security situations.</p>		<p>has policies and procedures for civil defence and other emergencies. There are enough supplies available, such as dressing and first aid equipment. There is an approved evacuation plan for the facility. Fire evacuation training and drills are conducted six monthly.</p> <p>Emergency equipment, water and food are available in a separate cupboard and routinely checked.</p> <p>Appropriate security systems are in place. The call system functions throughout and when activated they are responded to promptly. The service has a visitors' book at reception for all visitors including contractors, to sign in and out.</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>	<p>FA</p>	<p>Residents' rooms are provided with adequate natural light, ventilation, and in an environment that is maintained at a safe and comfortable temperature. Temperatures are routinely monitored.</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>	<p>FA</p>	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a comprehensive and current infection control manual, developed at organisational level, with input from the clinical co-ordinator/infection prevention and control officer (IPC). The infection control programme and manual are reviewed annually.</p> <p>The clinical supervisor/registered nurse is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager, and tabled at the quality/risk committee meeting. This committee includes the owners/directors/facility manager, clinical supervisor/IPC coordinator, charge nurses and the health and safety officer.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours not to enter the facility. The infection control manual provides guidance for staff about how long</p>

		they must stay away from work if they have been unwell. Staff interviewed understood these related responsibilities.
<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 infection prevention and control (IPC) coordinator has appropriate skills, knowledge and qualifications for the role, and has been in this since November 2015. She has undertaken IPC training and attended relevant study days, as verified in training records sighted. Well-established local networks with the infection control nurse specialist, Older Persons Health are available and expert advice from the laboratory is available if additional support/information is required. The IPC coordinator subscribes to an online NZ professional IPC forum. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The IPC coordinator confirmed the availability of resources to support the programme and any outbreak of an infection.</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 prevention and control policies reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies are reviewed yearly and include appropriate referencing.</p> <p>Care delivery, cleaning, laundry and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand-washing technique and use of disposable aprons and gloves. Hand washing and sanitiser dispensers are readily available around the facility. Staff interviewed verified knowledge of infection control policies and practices.</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>Priorities for staff education are outlined in the infection control programme annual plan. Interviews, observation and documentation verified staff have received education in infection prevention and control at orientation and ongoing education sessions. Education is provided by suitably qualified registered nurses, and the infection control coordinator. Content of the training is documented and</p>

		<p>evaluated to ensure it is relevant, current and understood. A record of attendance is maintained.</p> <p>When an infection outbreak or an increase in infection incidence has occurred, there is evidence that additional staff education has been provided in response. An example of this occurred in December 2015 when there was a norovirus outbreak in the facility affecting residents and staff.</p> <p>Education with residents is generally on a one-to-one basis and has included, reminders about handwashing, advice about remaining in their room if they are unwell, and increasing fluids during the norovirus outbreak. Families confirmed they also were given education by staff during the outbreak.</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>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for long term care facilities, with infection definitions reflecting a focus on symptoms rather than laboratory results. These include urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. When an infection is identified, a record of this is documented in the individual infection register in the resident's clinical record, infection reporting form, and resident management system. The infection control coordinator reviews all reported infections. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the clinical manager, facility manager/ owners/directors. Data is benchmarked with other aged care providers of a similar size. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Surveillance results are then shared with staff at the registered nurses and general staff meetings, as confirmed in meeting minutes sighted and interviews with staff.</p>

		A summary report of the norovirus infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures for the use of restraints and enablers which comply with the standard. All alternatives to restraints are considered and used before any restraint is considered.</p> <p>On the days of audit there were seven residents with restraints in use. There were two residents with enablers. The restraint coordinator was interviewed in relation to this standard. She has held the position for about a year, has attended all training provided at the facility. She demonstrated her understanding of restraint as a last resort and the restraint and enabler procedures.</p> <p>Restraints and enablers are assessed, approved, managed, monitored and reviewed. The residents' files were reviewed and all documentation was current and as described in the organisation's policies and procedures.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The clinical supervisor is the restraint coordinator. She has a signed job description, and understands the role and her responsibilities. All residents with a restraint in use are required to have an assessment and consent form and regular monitoring documented. This was evidenced in three residents' files who are using restraint. The restraint approval group meets monthly to review the register. Restraint is reviewed with individual residents monthly.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Either the clinical supervisor or a RN undertake all restraint assessments.</p> <p>Restraint assessments are based on documentation in residents' files, family and resident discussions and on observations from staff. There was a restraint assessment tool completed for the three hospital</p>

		residents' files reviewed for residents requiring bedrails and lap belts for safety. The care plan was up-to-date and included the risks and interventions associated with restraint use. Ongoing consultation with the resident and family was also identified. InterRAI assessments identified risks and the need for restraint.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>The organisation has an approval process that is reflective of the standard. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions to try before restraint is used. This was confirmed during interview with the clinical supervisor.</p> <p>The three hospital residents' files were reviewed for restraint and there was evidence in the documentation that other strategies were considered before the use of restraint. The care plans reviewed identified observations, monitoring and family involvement. Restraint use is reviewed three monthly with the GP, at six monthly care plan evaluations, and monthly at registered nurse meetings and the restraint/infection control meeting. A restraint register is in place, which is current for the residents requiring restraints and enablers.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The facility's restraint evaluation includes the areas identified in this standard. Evaluation has occurred monthly as part of the ongoing reassessment for the resident on the restraint register, and as part of their six-monthly care plan review. The family and the GP is included as part of the review.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint co-ordinator in conjunction with the restraint committee undertakes a comprehensive review of all restraints at least monthly, and each restraint independently with the GP three monthly. The documented review process sighted includes all aspects a) to e) in the standard.

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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 1.2.3.7</p> <p>A process to measure achievement against the quality and risk management plan is implemented.</p>	PA Low	<p>Quality improvement activities are undertaken as part of quality and risk management. This includes a scheduled audit programme. Activities include internal audits, complaints process, quality and staff meetings, and analysis of events. A resident survey is conducted annually. Internal audits include cleaning, laundry, kitchen and food service, building compliance, the admission process, staff and resident files, wounds and pressure injuries, weight loss, continence, and medication management. While the clinical supervisor has completed wound, pressure injury and weight loss audits, there are still some audit omissions in the system.</p>	<p>There is not one person providing oversight for quality audits and audit gaps have emerged. The quality manager collates and analyses data, facilitates meetings and the internal audit programme, providing staff with the relevant tools, and completes some audits herself. The quality assurance team leader has multiple roles including quality and undertaking some audits. Completed audits are in three folders and there is no system to ensure these are completed on time.</p> <p>Medication management audits are completed by a non-clinical staff member and the continence audit – due in August – has not been completed.</p>	<p>Ensure all internal audits are completed by an appropriate person and according to the audit plan.</p> <p>180 days</p>

<p>Criterion 1.4.2.1 All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>There is a preventative maintenance schedule in place for all products, electrical, building and fire equipment. This is current and monthly checks routinely occur. However, general repairs and maintenance is not always documented or checked. For example, paint chips, scuffs, loose tiles have not been identified for needing repair or routinely checked. The diaries used for staff to log issues requiring attention or repair are not always marked off and signed, dated when completed, as noted in seven entries in one diary since 19 October 2016.</p>	<p>The system for ongoing maintenance and repairs is incomplete.</p>	<p>Ensure there is a documented system and routine check for ongoing maintenance and repairs.</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.