

# The Willows Home and Hospital Limited - The Willows Home and Hospital

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## 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:

<b>Legal entity:</b>	The Willows Home and Hospital Limited	
<b>Premises audited:</b>	The Willows Home and Hospital	
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
<b>Dates of audit:</b>	Start date: 7 February 2017	End date: 8 February 2017
<b>Proposed changes to current services (if any):</b>	None	
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	17	



# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

The Willows Home and Hospital (The Willows) is privately owned. It offers hospital and rest home level care services for up to 28 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, procedures, residents and staff files, observations and interviews with residents, families/whānau, one general practitioner, management and staff.

There are six areas identified as requiring improvement related to documentation of complaints, corrective action documentation, two areas of medication management, building and equipment compliance and review of the infection control programme.

## 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.		Some standards applicable to this service partially attained and of low risk.
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Staff demonstrated knowledge and understanding of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code of Rights). Residents and family/whanau are informed of their rights during the admission process and ongoing residents' meetings. There are copies of the Code of Rights posters and information relating to the Nationwide Health and Disability Advocacy Service accessible throughout the service.

Residents and family/whanau receive clinical services that have regard for their dignity, privacy and independence. The residents' ethnic, cultural and spiritual values are assessed at admission to ensure they receive services that respect their individual values and beliefs, including for those residents who identify as Maori. There are processes to access interpreting and translating services as required.

Evidence-based practice is supported and encouraged to ensure residents receive services of an appropriate standard. Residents have access to visitors of their choice and are supported to access community services.

Evidence was seen of informed consent and open disclosure in residents' files reviewed. There are advance care plans and advance directives that record the residents' wishes, with these respected by the staff.

The Willows supports the right of residents, family/whanau and visitors to make a complaint. The service has a complaint register and the information is recorded to meet all the requirements of the standard. There were no outstanding complaints at the time of audit.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The organisation's philosophy, mission and vision statements are identified in policy. There is an annual business plan that underpins decision making, policy and the budget. The business plan is available to all staff and it contains a quality policy which identifies quality and risk management strategies to ensure services meet residents' needs, and that legislation and good practice standards are followed.

The governance structure is documented to show there is one owner/manager who is responsible for all aspects of service delivery. The owner/manager is supported by one manager/maintenance person who oversees non-clinical aspects of service and one clinical manager who oversees all clinical aspects of care. All three members of the management team work full time in the business.

The quality and risk system and processes support effective, timely service delivery. The quality management systems include an internal audit process, complaints management, incident/accident reporting, annual resident/family/whānau surveys, restraint and infection control data collection. Quality and risk management activities and results are shared among management, staff, residents and families/whānau, as appropriate. There is a process covering corrective action planning. Incident and accident management occurs to meet policy requirements; this includes reporting of adverse events to appropriate authorities.

The day to day operation of the facility is undertaken by staff that are appropriately experienced, educated and qualified. Residents and families/whānau confirmed during interview that all their needs and wants are met.

The service implements the documented staffing levels and skill mix to ensure contractual requirements are met. Human resources management processes implemented identify good practice and meet legislative requirements.

The privacy of residents' information is maintained. Residents' files are well presented and easy to navigate and records are integrated.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Entry to the service is clearly defined in policies. If a potential resident is declined entry to the service, this is recorded and the referrer informed.

The organisation has systems and processes implemented to assess, plan and evaluate the care needs of residents requiring hospital and rest home level care. Staff are qualified to perform their roles and deliver all aspects of service delivery. The clinical manager oversees the care and management of all residents, along with a team of staff. All residents are assessed on admission and assessment details are retained in the individual resident's record.

The residents' care plans document the needs, outcomes and/or goals and these are reviewed six monthly, or more often as required. The service uses a mix of electronic and paper based assessment tools. The residents, and where appropriate the family/whanau, are involved in the care planning and review.

The activities available are appropriate for residents requiring hospital and rest home level care, including the needs of younger people under the age of 65.

A safe medication prescribing, administration and storage system was observed. The registered nursing staff have been assessed as competent to perform their role.

The menu plans have been reviewed by a dietitian. Each resident is assessed by the RN and clinical manager on admission for any identified needs in relation to nutritional status, weight, likes and dislikes. The kitchen complies with current food safety legislation and guidelines.

## Safe and appropriate environment

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The service has processes in place to protect residents, visitors and staff from harm as a result of exposure to waste or infectious substances.

There are documented emergency management response processes which are understood and implemented by staff. This includes six monthly fire evacuation drills.

The building has a current building warrant of fitness and an approved fire evacuation plan. There have been no changes to the facility footprint since the previous audit.

The facilities meet residents' needs and appropriate furnishings and equipment is provided. All bedrooms are single occupancy. There is adequate toilet, bathing and hand washing facilities. Lounge and dining areas meet residents' relaxation, activity and dining needs.

The facility is electrically heated throughout and there are opening doors and windows in all resident areas to create a good air flow. The outdoor areas provide furnishings and shade for residents' use.

Residents and family/whānau were happy with the environment provided.

## 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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The policies and procedures in place cover all aspects of restraint minimisation and safe practice to meet standard requirements. Policy identifies that enablers are voluntary and the least restrictive option to allow residents to maintain independence and safety. At the time of audit there are no restraints or enablers in use. The managers encourage a restraint free facility.

Staff receive annual education related to restraint. An annual review of restraint policy, procedures and processes was conducted in May 2016.

## 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.		Some standards applicable to this service partially attained and of low risk.
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There is a documented and implemented infection control programme which is appropriate to the service.

Infection prevention and control policies and procedures are clearly documented and implemented to minimise risk of infection to residents, staff and visitors. The policies and education reflect current accepted good practice and are readily available for staff.

The type of infection surveillance undertaken is appropriate to the size and type of the service. Results of surveillance are acted upon, evaluated and reported to relevant staff in a timely manner.

## Summary of attainment

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

<b>Attainment Rating</b>	<b>Continuous Improvement (CI)</b>	<b>Fully Attained (FA)</b>	<b>Partially Attained Negligible Risk (PA Negligible)</b>	<b>Partially Attained Low Risk (PA Low)</b>	<b>Partially Attained Moderate Risk (PA Moderate)</b>	<b>Partially Attained High Risk (PA High)</b>	<b>Partially Attained Critical Risk (PA Critical)</b>
<b>Standards</b>	0	40	0	3	2	0	0
<b>Criteria</b>	0	87	0	4	2	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Staff demonstrated their knowledge of the Code of Health and Disability Services Consumers' Rights (the Code). Residents' rights are upheld by staff (eg, 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 interacted with residents in a way that respects residents' rights.</p> <p>The residents reported that they understand their rights, and all spoke highly of the manner they are treated by all staff. The family/whānau reported that residents 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. Residents and family/whānau (where appropriate) are included in care decisions.</p> <p>There are guidelines in the policy for advance directives which meet legislative requirements.</p>

		The consent can be reviewed and altered as the resident wishes. Advance directives and advance care plans are used to enable residents to choose and make decisions related to end of life care. The files sampled have signed advance directive forms and advance care plans that identify residents' wishes and meet legislative requirements.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Advocacy information is available in brochure format at the entrance to the facility. Residents and family/whanau are aware of their right to have support persons. Education from the Nationwide Health and Disability Advocacy Service forms part of the in-service/online education programme. The staff reported knowledge of residents' rights and advocacy services.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Policy includes procedures to be undertaken to assist residents to access community services. Residents reported they are supported to be able to remain in contact with the community through outings and walks. Residents, including younger residents, were observed to be going offsite, either independently or with family/whanau/friends. Family/whanau reported that their relatives are supported to attend off site cultural activities or places of worship, if they themselves are not able to take them.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	PA Low	Policy and procedure reflect complaints management processes that comply with Right 10 of the Code. Complaints forms are available at the front desk and accessible to staff, visitors and residents. Staff confirmed that any complaints they receive they pass onto the owner/manager. Written complaints are placed in the complaints register which identifies all actions taken.  There are no outstanding complaints at the time of audit. All complaints have been managed and closed off by the owner/manager.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	On admission to the services, residents and family/whanau are provided with the Code information. Opportunities for discussion and clarification relating to the Code are provided to residents and their family/whanau.  Brochures on the Nationwide Health and Disability Advocacy Service are on display at the service. There are Code posters (in English and other languages) on display.

		Education is provided on the Nationwide Health and Disability Advocacy Service as part of the in-service/online education programme. Residents are addressed in a respectful manner as was confirmed through observations and interview with residents and family/whanau.
<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>	FA	<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 resident related information. The service has a number of younger people and their independence and links with the age appropriate community resources is encouraged. The residents interviewed and files sampled evidenced that the individual values and beliefs of the residents are respected. There were no concerns expressed by the residents and family/whānau about abuse or neglect. One of the younger residents commented on how well their independence is supported at the service.</p> <p>Staff report knowledge of residents' rights and understand the principles of dignity and respect and what to do if they suspected the resident was at risk of abuse or neglect.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The cultural awareness policy includes guidance for staff on the provision of culturally appropriate care to residents who identify as Maori. A commitment to the Treaty of Waitangi is included. The owner/manager reports that there are no known barriers to Maori accessing the services.</p> <p>Family/whanau input and involvement in service delivery/decision making is sought if applicable. The in-service education programme includes cultural safety. Staff demonstrated an understanding of meeting the needs of residents who identify as Maori and the importance of whanau. There are some residents who identify as Maori at the time of audit, with a file sampled reflecting culturally safe practice. A resident interviewed reported that their Maori beliefs are respected and supported by the staff. The resident reported that they feel 'at peace' and 'at home' at The Willows.</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,</p>	FA	<p>The service has a multi-cultural mix of residents. The cultural and/or spiritual needs of the resident are provided for in consultation with the resident and family as part of the admission process and ongoing assessment. Specific food preferences are identified on admission, with residents and family/whanau reporting the service 'excels' at meeting their cultural needs.</p> <p>Each section/need of the care plans sampled incorporate the resident's individual cultural</p>

<p>cultural, spiritual values, and beliefs.</p>		<p>needs to provide guidance and ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with the resident's individual values and beliefs. 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>Staff confirmed the need to respect the individual culture, values and beliefs of residents.</p>
<p>Standard 1.1.7: Discrimination 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 stated they would report any inappropriate behaviour to the owner/manager (or RN/clinical manager). The staff contracts and files record that professional boundaries are included in contracts and the RNs have attended the required Nursing Council of NZ Code of Conduct training. There was no evidence of any behaviour that required reporting and interviews with residents and families/whanau indicated no concerns. All residents and family/whanau interviewed reported high praise for the manner in which they are treated by all levels of staff.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies and procedures based on evidence based practice. The planned education programme sampled included sessions that ensures an environment of good practice. The service has access and support from visiting specialist nurses, palliative services and mental health teams. The general practitioner (GP) visits the service at least weekly, and at other times as required to the respond to changes in a resident's condition.</p> <p>Residents' and family/whānau satisfaction surveys evidenced overall satisfaction with the quality of the care and services provided. The GP reported the service provides 'excellent' quality of clinical care to residents at the different levels of care, with some residents being 'very complex'. The GP also commented that the clinical manager has excellent clinical knowledge and assessments skills and the clinical nurse shares this knowledge with other nurses.</p>
<p>Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>The cultural policy notes interpreters will be accessed if required. Prior to admission of residents who do not speak English, a senior staff member will offer the availability of the interpreting services to the resident and/or their family. This service can be contacted through the DHB. Files sampled of residents who do not speak English show there are effective</p>

		<p>methods of communication implemented.</p> <p>Evidence was seen that all aspects of care and service provision are discussed with the resident and their family/whanau prior to/or at the admission meeting. The residents and family/whanau report that communication is open and honest. Open disclosure is documented and is noted on incident forms and other communications (eg, emails with family/whanau that do not live in Auckland).</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>	FA	<p>The Willows is privately owned. The owner/manager works in the facility full time and has owned and operated the facility since 1999. The owner/manager is supported by the manager/maintenance person and the clinical manager who is a registered nurse with a current practising certificate. There have been no changes to the management structure since the previous audit.</p> <p>There is an annual business plan that underpins decision making, policy and budget. This contains a quality policy which identifies the actions taken to maintain quality and risk processes. The organisation's philosophy is clearly documented. Annual goals are set and reviewed by the management team.</p> <p>On the day of audit, the service had 17 residents. Six rest home level care and 11 hospital level care residents. There are three residents who are under the age of 65 years two are under an ACC contract and one is under the Age Related Residential Care contact.</p> <p>The management team work together to ensure all residents' needs are met by the services provided. All members attend ongoing clinical and management education.</p> <p>The staff also attend regular education to maintain their skills and knowledge. Accountability and responsibilities for each role was clearly described in the job descriptions sighted.</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 the owner/manager, the clinical manager undertakes the role with assistance from the manager/maintenance person. When the clinical manager is on leave, the role is shared among the senior (RN) nursing staff. During interview, the owner/manager confirmed they are always available by phone should any situations occur or ongoing advice is required.</p> <p>Staff confirmed that there is no disruption to services when the managers are on leave.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>PA Low</p>	<p>The quality and risk management systems are understood and implemented by service providers. This includes the update of policies and procedures by an external provider, regular internal audits, incident and accident reporting, health and safety processes, infection control data collection and management and complaints management. Meeting minutes sighted identify that all quality and risk data is shared and they cover the key performance indicators including the non-use of restraint.</p> <p>Data for the before-mentioned items is collected, reviewed and trended against previously collected data. The corrective actions that are documented show outcome results following management review. Staff confirmed they are informed of all required corrective actions by memo or at shift handover.</p> <p>The annual resident/family/whanau annual satisfaction survey results sighted did not have corrective action follow-up documented. However, the owner/manager stated that the issues had been addressed but not documented. This was confirmed by a resident and family/whanau during interview.</p> <p>Quality improvements are undertaken to meet the requirements of the standard and continuous quality actions were sighted for falls management and upgrades to the environment.</p> <p>There is a process in place to ensure policies and procedures are reviewed at least two yearly or sooner if required to meet legislative changes. All policies and procedures were reviewed and updated in September 2016 and personalised to the service. Policies reflected good practice and meet legislative requirements. This includes showing the updated health and safety requirements and the need to report level three and above pressure injuries via section 31 of the Health and Disability Services (Safety) Act 2001.</p> <p>Actual and potential risks are identified using the quality and risk planning processes. Newly found hazards are discussed, monitored and managed by the manager/maintenance person with staff input. There is an up to date hazard register which was reviewed in September 2016. Staff confirmed that they understood and implemented documented hazard identification processes.</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</p>	<p>FA</p>	<p>Adverse event reporting, as identified in policy, is implemented by the service. Policy outlines all reporting requirements including Section 31 of the Health and Disability Services (Safety) Act 2001. The owner/manager confirmed their awareness of the organisation's requirement related to statutory and or/regulatory reporting obligations. One Section 31 notification to the</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>Ministry of Health was sighted.</p> <p>Staff interviewed stated they report and record all incidents and accidents and that this information along with any corrective actions is documented on the form. Information is shared at staff meetings, as confirmed in minutes sighted. Documentation in residents' files and the 2016/2017 incident and accident forms reviewed identified that all issues reported had corrective actions put in place when required. The incident and accident forms are viewed and signed off by the owner/manager.</p> <p>The principles of open disclosure are evident with clearly documented family/whānau notification of any adverse event or concerns staff may have about a relative's health status. This was confirmed during family/whānau interviews.</p> <p>Management reported during interview that information gathered from incident and accidents is used as an opportunity to improve services where indicated and examples were given. Incident and accident numbers are trended and if there is an increase identified an explanation is given and appropriate actions are taken.</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>FA</p>	<p>Policies and procedures implemented identify human resource management that reflects good employment practice and meet the requirements of legislation. This was confirmed in the staff files reviewed. All roles have job descriptions that describe staff responsibilities and accountabilities. Staff complete an orientation programme with specific competencies for their roles. (Refer comment in criterion 1.3.12.3 regarding healthcare assistants (HCAs) medication competencies). Staff confirmed during interview that the orientation/induction process is overseen by a senior member of staff and that they felt confident to undertake their roles upon completion of orientation.</p> <p>Documentation in the staff files reviewed confirmed all RNs have completed annual medication competencies, and that staff attend both onsite and off-site education related to the roles they perform.</p> <p>Staff that require professional qualifications have them validated as part of the employment process and on an ongoing annual basis. Employment processes included reference checking and annual staff appraisals. All appraisals were up to date for the seven staff files reviewed. Three RNs are interRAI competent and two managers have administrative access.</p> <p>The education calendar sighted for 2016 and 2017 identifies that staff are offered and undertake training and educational topics relate to aged care and health care services. The services use on-line staff education related to aged care which covers all aspects of the key performance indicators. Education sessions are presented at the facility and staff are</p>

		<p>informed of upcoming off-site education sessions. Attendance for all education is documented in staff files.</p> <p>HCA's are encouraged to undertake a recognised aged care qualification. RNs have undertaken the required hours of education to meet Nursing Council requirements. Members of the management team also attend workshops and seminars specific to management related topics.</p> <p>Resident and families/whānau members interviewed, identified that staff act professionally and meet their rights at all times.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>Policy that identifies staffing levels and skill mix is maintained to meet residents' needs and to comply with contractual requirements. Documentation identifies that at all times adequate numbers of suitably qualified and experienced staff are on duty.</p> <p>Rosters sighted showed that staff were replaced for sickness and annual leave. This was confirmed during interview with staff and management. Staff reported they had adequate time to complete all required tasks to meet residents' needs. There is a RN to cover all shifts and at least one staff member on each shift who holds a current first aid certificate. Additional staff are rostered to reflect the occupancy and workload.</p> <p>Resident and family/whānau members interviewed stated all their needs have been met in a timely manner.</p> <p>The service has dedicated kitchen and activity staff. Cleaning and laundry is undertaken by HCA's as part of their everyday duties.</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>	FA	<p>Personal information is entered in all residents' records reviewed. Records reviewed evidenced that entries are being documented at appropriate intervals, are legible with signatures and staff designations included. All individual records were integrated with divisions labelled accordingly.</p> <p>The records are stored in the nurses' stations which have locked access. There were some records (such as short term care plans/wound treatment plans) kept in a separate folder, these were integrated into the residents' record when the issue is addressed (the resident's main file referring the reader to any other associated documents). Residents' other personal/financial documents are stored in the owner/manager's office. A system is in place for accessing archived records if and when required.</p>

		Resident information is not displayed in public view without consent being obtained.
<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>The admission policy includes the procedure to be followed when a resident is admitted to the home. The admission agreement contains all required information and is based on an Aged Care Association agreement (part of the organisation wide policies and procedures). Entry screening processes are documented and communicated to the resident and their family/whanau to ensure the service is able to meet the needs of the resident. The residents and family/whanau reported the admission agreement was discussed with them prior to admission and all aspects were understood. Needs assessments from various funders (eg, DHB, ACC) for either rest home or hospital level of care are sighted in the resident's files sampled.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>All residents' exit, discharge or transfer is documented using specific forms. The service utilises the transfer forms approved by the DHB and this was confirmed in files reviewed. Known risks are identified to the place of transfer in order to manage the resident safely. Expressed concerns of the resident and family/whānau are clearly documented including advance directives and EPOA documentation. This was confirmed during residents' file reviews.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	PA Moderate	<p>Policies and procedures describing safe medication management are implemented by the service. With the exception of liquid medicines and stock medications, such as antibiotics, medicines are supplied by the pharmacy in a pre-packed robotics administration system for individual residents. Medications are checked for accuracy by the RN when delivered, with this recorded on the electronic medication record. Safe medicine administration was observed at the time of audit. There is an area for improvement in ensuring the weekly checks of the controlled drugs are constantly conducted (refer to 1.3.12.1) and that the HCAs who double check the controlled drugs are assessed as competent to do so (refer to 1.3.12.3).</p> <p>There is policy in place which describes the process to follow for residents who are deemed competent to self-administer medicines. No residents were self-administering their medications at the time of audit.</p> <p>All the medication records sampled have prescriptions that complied with legislation and aged care best practice guidelines. The GP has conducted medication reviews for all</p>

		<p>residents within the last three months.</p> <p>The RNs are responsible for the medicine management and all administration. Current medication competencies are sighted for all RNs.</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>Policies and procedures implemented cover all aspects of food preparation. Documentation identifies that safe food hygiene management practices are followed.</p> <p>The menu has been reviewed by a registered dietitian as being suitable for the residents living in a long term care facility. The cook stated that food is produced in accordance with the menus. The kitchen has dietary information for all residents and their likes and dislikes are catered for. Residents are routinely weighed at least monthly, and more frequently when indicated. Residents with additional or modified nutritional needs or specific diets have these needs met. The residents and family/whānau reported being overall satisfied with the meals and fluids provided, including catering for their individual cultural preferences.</p> <p>Food, fridge and freezer recordings are undertaken daily and meet requirements. The kitchen staff have completed safe food handling courses. There are some chipped surfaces on the kitchen benches (refer to criterion 1.4.2.1).</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>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. The service was not able to provide services to a recent bariatric resident. The clinical manager reported that they refer residents to different levels/types of care if they are unable to support the resident (such as psychogeriatric or secure dementia care).</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 assessment, which includes assessment of the resident's health and personal care needs is completed on the day of admission. Registered nurses utilise standardised risk assessment tools for the initial and ongoing assessments. The interRAI, along with other paper based assessments, information gained from the resident and their family/whānau, referral information, observations and examinations carried out are used as a basis for developing the long term care plan. The residents and family/whānau expressed satisfaction with the support provided.</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 all files reviewed evidence was sighted of interventions related to the desired outcomes. Risks identified on admission are included in the care plan and these included falls risk, pressure area risk and pain management. The assessment outcomes from the interRAI assessment process were included to update the care plan.</p> <p>All health professionals documented 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 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. The residents report satisfaction with the care provided.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The care plans reviewed were individualised to show interventions put in place to contribute to meeting resident goals. Information sighted on care plans was congruent with assessment findings. Residents and family/whānau interviewed reported satisfaction with the services they receive. The clinical staff reported that they are informed of any care plan changes at the shift hand over and receive 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>The activities coordinator plans activities to meet the resident's abilities, this includes the needs of the younger people at the service. Information gained by an activities assessment and resident's history assessment is used when developing the activity plan. The activities coordinator reported they focus on giving the residents back some independence by focusing on activities that are meaningful.</p> <p>There are planned activities that cover physical, social, recreational and emotional needs of the residents. The activities programme is an evolving plan to match weather conditions and resident's abilities. The activities coordinator visits each resident in the morning to remind them of the planned activities for that day and ask for any further suggestions for the day's activities. Feedback received from the residents and family/whānau is taken into account when planning activities. The residents (including younger people) report that the activities programme is of interest to them.</p>

<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Individual short term care plans were seen for wound care, infections and weight loss. These are kept in the resident's folder and during each shift documentation is made in the file as required.</p> <p>Long-term care plans are reviewed every six months or earlier as required. Evidence was seen of family involvement in the care reviews. In files reviewed there was evidence of documentation if an event occurred that was different from expected and required changes to services. The residents and family/whanau reported that they are given the opportunity to be involved in all aspects of care and reviews. The clinical staff interviewed have knowledge of the care plan documentation requirements.</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>Residents may use the GP of their choice if they do not wish to access the main GP that regularly visits the service. Referrals to other health providers are supported by the organisation and facilitated by the GP and RNs. This was confirmed in residents' file reviews and during resident and family/whānau interviews.</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 is implemented to ensure safe and appropriate storage and disposal of waste substances. Yellow sharps bins are used for the safe disposal of medical waste, such as needles. Staff report their understanding of safe disposal processes.</p> <p>Chemicals are stored securely and correctly labelled. Safety data sheets were sighted for the chemicals in use. There is a chemical products reference chart on the wall in the laundry area where the majority of chemicals are stored.</p> <p>Personal protective equipment/clothing (PPE) sighted included disposable gloves, aprons and goggles. Staff interviewed confirmed they can access PPE at any time and were observed wearing disposal gloves and aprons as required.</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</p>	<p>PA Moderate</p>	<p>Documentation sighted identified that all processes were undertaken as required to maintain the building warrant of fitness. The facility has a current building warrant of fitness which expires 9 February 2018.</p> <p>Maintenance occurs both as planned annual maintenance and day to day reactive</p>

<p>purpose.</p>		<p>maintenance. Specialised areas, such as plumbing and electrical work, is undertaken by external contractors and minor repairs are undertaken the manager/maintenance person. Not all painted surfaces are intact.</p> <p>Electrical safety testing last occurred in 2015. Clinical equipment is tested and calibrated by an approved provider at least annually and was last undertaken in July 2016.</p> <p>The physical environment minimises the risk of harm and safe mobility by ensuring bathroom floors are non-slip and walking areas are kept clear of obstructions. Staff verbalised their awareness of maintaining a safe environment.</p> <p>Outdoor areas are easily accessed by all residents and there is appropriate seating and shaded areas. Resident and family/whānau use of the outdoor areas were observed on the days of audit.</p> <p>Interviews with residents and families/whānau members confirmed the environment is suitable to meet their needs.</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>	<p>FA</p>	<p>There are adequate toilet and shower facilities. There are four bathroom areas, one located in each wing. Six bedrooms have a shared toilet and wash basin between two room (3 toilets), one bedroom has a full ensuite and 16 bedrooms have toilet and hand basin ensuites.</p> <p>Hot water temperatures are monitored to ensure they remain within safe limits for residential care.</p>
<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>	<p>FA</p>	<p>All bedrooms are single occupancy and are of a size which allows enough space for residents to mobilise safely with or without assistance. They are personalised to meet resident's wants and needs and have appropriate areas for residents to place personal belongings.</p> <p>Resident and families/whānau members interviewed confirmed they are happy with their personal space.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p>	<p>FA</p>	<p>Residents are provided with adequate areas to meet their relaxation, activity and dining needs. The large lounge area is used by the majority of residents with a dining area which is</p>

<p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>		<p>divided by furnishings. A smaller lounge area is also available. Activities occur in the large lounge as observed on the days of audit.</p> <p>Residents and families/whānau voiced their satisfaction with the environment.</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>The service has documented policies and procedures in place for cleaning and laundry tasks. The laundry is all undertaken on site and the staff confirmed they have adequate equipment to undertake this task. Laundry chemicals for the washing machines are on an automatic feed to ensure the correct amount of detergent is used for each wash.</p> <p>The chemicals for cleaning are kept in their original bottles which are clearly labelled. The cleaners' trollies are stored in secure areas when not in use.</p> <p>The poor return rate of residents' personal laundry was an issue identified in the satisfaction survey results. However, during interview on the days of audit residents and families/whānau confirmed they were very happy with the cleaning and laundry services provided.</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>Documented emergency management procedures are implemented by staff in the event of an emergency. The emergency plan is reviewed annually as part of the quality process. (Last update occurred in September 2016). Emergency fire equipment is checked annually by an approved provider (October 2016) and there is an evacuation plan which was approved by the fire service in December 2008. There have been no changes to the facility footprint since this time. Six monthly fire evacuations are undertaken with the last one occurring in January 2017. No follow up actions were required.</p> <p>Emergency supplies and equipment include food and water, first aid kits and civil defence supplies. The contents are rotated regularly so that they do not expire. Six monthly checks were sighted. Alternative energy and utility sources are available in the event of the main supplies failing and include emergency lighting and a gas BBQ and cooking.</p> <p>The security arrangements involve staff ensuring the doors and windows are locked upon dusk. Staff and residents stated they feel safe at all times. There is CCTV monitoring in of the car park and the front entrance which can be seen on the screen in the nurses' office.</p> <p>Call bells are located in all resident areas. Residents and families/whānau interviewed confirmed call bells were answered in an acceptable timeframe. The owner/manager monitors response times as part of the quality processes.</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>All resident areas have at least one opening window which provides natural light and ventilation. The facility has electric heating throughout the facility, including in resident bedrooms.</p> <p>Residents confirmed that the facility is maintained at a comfortable 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>	PA Low	<p>The clinical manager is the designated infection control coordinator, with support from the owner/manager. They have a job description that outlines their roles and responsibilities for infection prevention and control. Infection control matters are discussed at the staff meetings and the combined infection control/quality/safety committee meetings. The owner receives the monthly quality, risk and infection control issues.</p> <p>There are current processes in place to ensure staff and visitors suffering from infections do not infect others. There is a notice at the front door to advise family/whanau not to visit if they are unwell. There is sanitising hand gel located throughout the facility for staff, visitors and residents to use. Staff demonstrated good knowledge and application of infection prevention and control principles.</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 infection control coordinator oversees the infection control programme, with implementation the responsibility of all staff. Infection control matters are discussed at the monthly staff meeting and evaluation occurs at the two monthly safety committee. If the infection control coordinator requires additional advice or support regarding infection prevention and control they can access this through the DHB or GP.</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</p>	FA	<p>The infection control policies and procedures have been developed by an aged care consultant, have been personalised to the service and reflect current accepted good practice. The policies have been reviewed with the last six months.</p> <p>Staff demonstrated knowledge and understanding of standard precautions and stated they undertake actions according to the policies and procedures. Staff were observed to be washing hands and using personal protective equipment appropriately.</p>

are practical, safe, and appropriate/suitable for the type of service provided.		
<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>The infection control coordinator conducts most of the infection control education. There are some visiting specialists who provide infection control education. The infection control coordinator demonstrated current knowledge in infection prevention and control. They have attended ongoing education on current good practice in infection prevention and control.</p> <p>As required, infection control education can be conducted informally with residents, such as reinforcement of infection control practices with washing hands, blowing noses, cough etiquette and personal hygiene.</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>The service uses standardised definitions applicable to aged care that are provided by the external benchmarking service to identify infections. The type of surveillance undertaken is appropriate to the aged care service with data collected on urinary tract infections, influenza, skin infections and respiratory tract infections. There is monthly collection and collation of the types and numbers of infections in both the rest home and hospital services. Outcomes are fed back to the staff at the next staff meeting. The infection surveillance records included the review and analysis of the data. With an increase in the number of urinary tract infections in December 2016, the service has implemented actions to reduce the recurrence and spread of these infections.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policy and procedures reflect the safe use of restraint and the related procedures cover all aspects of the restraint minimisation standards. The use of enablers is voluntary and the least restrictive option to meet the needs of residents. The service encourages a restraint free home.</p> <p>The service has no restraint or enablers in use at the time of audit. Staff and management are aware that if a restraint event occurs that all aspects of the restraint minimisation standard requirements must be met. Staff have had annual education related to managing challenging behaviour and how to de-escalate a situation should it arise. (March and April 2016)</p> <p>The GP, RN and owner/manager undertook an annual review of restraint policy, procedures and staff education in May 2016. No follow up actions were required.</p>



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.1.13.3</p> <p>An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken.</p>	PA Low	<p>Written complaints are followed up as required to meet policy. These are shown in the complaints register to include dates and actions taken. However, complaints that are verbalised are dealt with by the owner/manager immediately and are never documented to show the actions taken to resolve the issue raised. No follow up could found related to an issue raised about resident laundry not being returned in good condition. The owner/manager verbalised actions she had taken to correct this but confirmed she did not document the family members concern as it was addressed immediately.</p> <p>Interviews with residents and family/whanau confirm that any issues they do raise are dealt with promptly and they are informed of actions taken.</p>	<p>Complaints that are verbalised and deemed of a minor nature, such as issues around laundry, are not documented in the complaints register. No follow up actions are documented related to this issue.</p>	<p>Provide evidence that all complaints are documented and recorded in the complaints register.</p> <p>180 days</p>

<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action planning was sighted for audit outcomes and complaints management follow-up. Some corrective actions, such as the use of sensor mats, is identified in progress notes and in staff meeting minutes but not on specific corrective action forms as required in policy. Documented evidence could not be located for all corrective actions. One example related to the resident satisfaction survey (2016) results showing dissatisfaction with laundry services. When discussed with management they stated that this issue had been addressed verbally with residents and staff but was not documented. One resident and their family/whanau member confirmed this issue had been fully addressed by the service and that they were satisfied with the outcome.</p>	<p>Corrective action documentation is not undertaken consistently.</p>	<p>Provide evidence that all matters requiring a corrective action are documented.</p> <p>180 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	PA Moderate	<p>The medicines, controlled drugs and medicine trolley are securely stored. Two staff sign the controlled drug register when medication is given and a physical check is conducted for the six monthly stock count. This was last conducted in December 2016. The control drug register records stock counts once a month in October, November and December 2016 and twice in January 2017. No count was recorded to date in February 2017.</p>	<p>The controlled drug register does not consistently show that weekly checks are undertaken.</p>	<p>Provide evidence that the weekly controlled drug checks are recorded in the controlled drug register.</p> <p>90 days</p>
<p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	PA Low	<p>The RNs are responsible for the medicine management and all administration. Current medication competencies are sighted for all RNs. While the RNs administer the medications, the health care assistants are required to check out the controlled drugs with the RN. There were no congruency training assessments sighted for these HCAs. The organisational policies and procedures require HCAs who perform this role to have an annual competency assessment.</p>	<p>HCAs who check controlled medication have not completed a documented competency check, as required by the organisational</p>	<p>Provide evidence that all staff who undertake any stage of medication management have a</p>

			policy.	documented competency.  Provide evidence that all staff who check medications are assessed as competent to perform their role.  180 days
<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Moderate</p>	<p>There is a current building warrant of fitness. Medical equipment is checked annually. Ongoing maintenance is evident with new ceilings in the hallways and recently laid carpet in bedrooms which are refurbished prior to being re-occupied. Electrical safety checks were last conducted in 2015 and this does not meet policy requirements. There are several areas where paint work is chipped exposing wood. For example, the shower and toilet doorframe and ceiling in room 56, hallway wall surfaces and the chipped area on the kitchen benchtop.</p>	<p>Electrical safety checks are overdue. Not all painted surfaces, including a chipped area in the kitchen benchtop, are of a standard to meet infection control cleaning standards.</p>	<p>Provide evidence of up to date electrical appliance checking, and that infection control cleaning standards can be met for all washable surfaces.  90 days</p>
<p>Criterion 3.1.3</p> <p>The organisation has a</p>	<p>PA Low</p>	<p>The policies and procedures have been reviewed in October 2016. The policies and procedures include a template for the annual review of the infection control programme. The template includes the review of the</p>	<p>The infection control programme has</p>	<p>Provide evidence that the</p>

<p>clearly defined and documented infection control programme that is reviewed at least annually.</p>		<p>effectiveness of the infection control programme, education, surveillance and equipment. This has not been completed in the past year.</p>	<p>not been reviewed in the past year.</p>	<p>infection control programme is reviewed at least annually.</p> <p>180 days</p>
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.