

# Kingswood Healthcare Matamata Limited - Kingswood Rest Home

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## Introduction

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

The audit has been conducted by 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>	Kingswood Healthcare Matamata Limited	
<b>Premises audited:</b>	Kingswood Rest home	
<b>Services audited:</b>	Dementia care	
<b>Dates of audit:</b>	Start date: 8 November 2017	End date: 8 November 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>	22	

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

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

## General overview of the audit

Kingswood Rest Home provides secure rest home care for up to 25 residents with dementia. The service is operated by Kingswood Healthcare Matamata Limited which is a private company. It is managed by the general manager with assistance from the administration manager who oversees all non-clinical issues, and a registered nurse who is the clinical manager. The clinical manager works between two facilities owned by the same people. There was a dedicated registered nurse at the facility who recently resigned, and a newly appointed RN commences on 21 November 2017. Residents appeared happy and families spoke positively about the care provided.

This surveillance audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with family members, residents, management, staff, and the nurse practitioner.

This audit has identified one area requiring improvement relating to first aid cover not being provided for all shifts.

## Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

A complaints register is maintained with complaints/concerns resolved promptly and effectively.

## 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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Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the general manager is regular and effective. An experienced person manages the facility.

The quality and risk management systems include collection and analysis of quality improvement data, identifies trends and leads to improvements. Feedback is sought from residents and families. Adverse events are documented with corrective actions implemented.

Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current and reviewed regularly.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery, and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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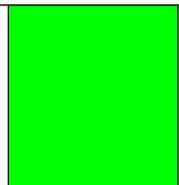
Residents' needs are assessed on admission, with reassessment occurring at least six monthly. Care plans/lifestyle plans are individualised, based on a range of information and accommodate any new problems that might arise. The files sampled demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis using the interRAI re-assessment process.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There is a current building warrant of fitness.

## 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 organisation has implemented policies and procedures that supports a restraint free environment. No enablers and no restraints were in use at the time of audit. A comprehensive assessment, approval and monitoring process is provided in policy should it be required. Policy identifies that enablers are voluntary for the safety of residents. Staff demonstrated a sound knowledge and understanding of how to maintain a restraint free environment. This facility is a secure unit for residents with dementia.

## Infection prevention and control

<p>Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.</p>		<p>Standards applicable to this service fully attained.</p>
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Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. Surveillance data is compared against aged care benchmarking rates.

## 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	15	0	1	0	0	0
Criteria	0	38	0	1	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 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The complaints/concerns policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints forms are available in the main corridor or from staff members.</p> <p>The complaints register reviewed showed that no complaints have been received over the past year, and two verbal concerns were raised. Documentation shows that actions were taken, through to an agreed resolution. The concerns have been treated as complaints and responded too within the same timeframes as a complaint. Action plans showed any required follow up and improvements have been made where possible. The general manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their/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. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Staff knew how to access interpreter services, although reported this was rarely required due to all residents being</p>

<p>consumers and provide an environment conducive to effective communication.</p>		<p>able to speak English or staff being able to provide interpretation as and when needed. The service has appropriate communication strategies for residents living with cognitive impairment.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>The strategic and business plans, which are reviewed annually, outline the mission statement, values, scope, direction and goals of the organisation. The documents describe annual and longer-term objectives and the associated operational plans. A sample of monthly reports to the general manager showed adequate information to monitor performance is reported including general business, financial matters, staffing, products, occupancy, education, infection control, incidents and accidents, medication errors and environment. Emerging risks and issues are identified. The facility operates using the Spark of Life philosophy.</p> <p>The day to day service is managed by the administration manager who has been in the role for six years. The general manager works across three sites and the clinical manager, who is a registered nurse with two years experience, works across two sites. The members of the management team undertake regular ongoing education with New Zealand Age Care Association, Waikato District Health Board (WDHB) forums, age care seminars and relevant clinical education presented by the nurse practitioner.</p> <p>Responsibilities and accountabilities are defined in job descriptions and individual employment agreements. The general manager and administration manager confirmed their knowledge of the sector, regulatory and reporting requirements.</p> <p>The service holds contracts with WDHB for Age Related Residential Care for rest home level dementia care. At the time of audit 21 residents were receiving services under this contract. One resident, who is unclassified, is being funded jointly from WDHB, Ministry of Health and Disability Support Link. The resident has a dementia diagnoses, and is sectioned under the mental health act for medication management. The general manager stated that it is yet to be determined what contract the resident is to be classified as. There is also a Residential Respite Service contract with the WDHB but no residents were receiving services under this contract at the time of audit.</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</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls and skin tears.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management team meetings, staff meetings and at daily handover. Staff reported their involvement in quality and risk management activities through audit activities and the implementation of</p>

<p>system that reflects continuous quality improvement principles.</p>		<p>corrective actions.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey (August 2017) showed that residents and family are happy with the services provided. One corrective action was put in place following the survey results when one resident's family member was unsure of the standard of meals. They were invited to partake in meals with their relative at any time. To date they have not taken this offer up.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed and updated by an off-site provider and personalised to Kingswood Rest Home. They are based on best practice and are current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The general manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The general manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements. There is an up to date risk register in place.</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>	<p>FA</p>	<p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. For example, a resident who was at high risk of falling and would not ring the call bell for assistance had a sensor mat placed in their bedroom and staff were made aware of the need for closer monitoring. This has resulted in no falls occurring. Adverse event data is collated, analysed and reported to the clinical manager, general manager and discussed at staff meetings. All incident and accident forms are signed off by the clinical manager once all actions have been implemented. It was noted that for the month of October only, neurological observations were not consistently being undertaken to meet policy requirements. (Refer to comments in 1.3.3.3.).</p> <p>The general manager and clinical manager described essential notification reporting requirements, including for pressure injuries. They advised there have been no notifications of significant events made to the Ministry of Health, since the previous audit. No police investigations, coroner's inquests, issues based audits and any other notifications have been made.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p>

<p>management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>Staff orientation includes all necessary components relevant to the role. All new staff have at least three shifts on each shift, (morning, afternoon and night shift) prior to being placed on the roster. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after three-months.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The nurse practitioner delivers much of the clinical education along with other guest speakers as appropriate. The administration manager is a Careerforce assessor and care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. There is always at least one staff member working who has completed dementia specific education. Of the 14 caregivers employed 12 are level two, one is level three, and one has been recently employed and has only just commenced the required training.</p> <p>The facility had a full time registered nurse who was interRAI trained but they recently resigned. A newly appointed registered nurse is to commence on the 21 November. The clinical manager is trained and competent and has maintained their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals. All interRAI assessments are up to date.</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>PA Low</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhour on call roster is in place, with staff reporting that good access to advice is available when needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. However, not every shift has a staff member on duty who holds a current first aid certificate. The shift leader was away on long leave in India, leaving a gap at this time of the day certain days of the week. Management are aware of this and documentation sighted identified that staff have been booked onto first aid updates on the 17 November 2017 at St Johns.</p> <p>The clinical manager is rostered three days a week and is on call, the activities coordinator works 9.30 to 4pm Monday to Friday, a dedicated cleaner works 7.30am to 2pm Monday to Friday and the administration manager works 8.30 to 4pm Monday to Friday and is on call. There are dedicated kitchen staff eight and a half hours per day, seven days a week.</p>
<p>Standard 1.3.12:</p>	<p>FA</p>	<p>The medicine management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management was observed on the</p>

<p>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>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>Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN or senior caregiver with medication competency checks medicines against the prescription. A record of these checks was sampled for the past three months. All medicines sighted were within current use by dates.</p> <p>There were no controlled drugs or standing orders at the time of audit.</p> <p>If medications require refrigeration, these are kept in a container in one of the fridges in the kitchen. No drugs require refrigeration at the time of audit.</p> <p>Best practice prescribing practices were noted and include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP or nurse practitioner review was consistently recorded on the medicine chart for nine of the ten medicine charts sampled, the remaining chart had a four-month gap between the recorded review. The file sampled was increased to 12 charts, with the remaining charts evidencing the required three-monthly reviews. Two of the medication charts identified medication allergies or sensitivities, with the pharmacy printed monthly signing sheet recording that there are no known sensitivities for these two residents. This was addressed at the time of audit, with the medicine charts faxed to the pharmacy, so the pharmacy has a record of the resident's sensitivities.</p> <p>All staff who assist with medicine management have a current competency assessment. There are no residents who self-administer medicines at the time of audit.</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 team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and was reviewed in 2015. 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 kitchen processes. The kitchen staff have 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. The staff can access food and fluids for the residents 24 hours a day to meet the nutritional needs of the residents. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by family interviews and satisfaction surveys. Residents</p>

		were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
<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 their plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The staff interviewed verified that medical and nurse practitioner input is sought in a timely manner and supporting the resident is based on the resident's individual needs and capabilities. Care staff confirmed that care was provided as outlined in documentation. A range of equipment and resources was available, suited to the level 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 activity coordinator is employed full time and has attended the course on Spark of Life. The activities coordinator is supervised by a diversional therapist from another care facility within the group who is a qualified teacher in the Spark of Life Philosophy.</p> <p>All the resident files sampled contained a 24-hour plan of how to manage behaviours. The planned and spontaneous activities are based on meaningful activities for the residents. Documentation is reviewed every six months and is part of family meetings. Clubs are part of the Spark of Life philosophy and files contained assessment tools to ensure which club is suitable for each resident. Family members reported overall satisfaction with the activities but felt there could be greater options for the residents who do not wish to participate in the planned activities.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections, wounds and pain management.</p> <p>When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</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>FA</p>	<p>A current building warrant of fitness expiry date 8 July 2018 is publicly displayed. There have been no changes to the facility footprint since the previous audit.</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 and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract and scabies. The infection control coordinator reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs, with short term care plans developed.</p> <p>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. Data is benchmarked against recognised guides for aged care. Where there has been an increase in infections, corrective actions are implemented. An example of this is when there was an increase in urinary tract infections, a corrective action plan was implemented. No infections were recorded in the subsequent months.</p> <p>There have been no recorded outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policy clearly states that the use of enablers shall be voluntary and the least restrictive option to meet the needs of residents with the intention of promoting or maintain independence and safety. Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator, the clinical manager, would provide support and oversight for enabler and restraint management in the facility should it be required. They demonstrated a sound understanding of the organisation's policies, procedures and practice and their role and responsibilities. The facility operates a restraint free environment.</p> <p>On the day of audit, no residents were using restraints and no residents were using enablers. This was confirmed in meeting minutes sighted, during staff interviews and in the restraint register.</p> <p>Restraint would only be used as a last resort when all alternatives have been explored. Staff have education in managing challenging behaviour and clinical practice maintains the Eden philosophy.</p>

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## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.8.1</p> <p>There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery.</p>	PA Low	<p>There are always at least two care staff on duty at all times with on call staff clearly identified. Not all shifts are covered by a staff member who holds a current first aid certificate. Staff have been booked on the next available first aid course.</p>	<p>Shifts not covered by a staff member who hold a current first aid certificate are Friday 4pm to 7pm and Wednesday and Thursday 10pm to 6am.</p>	<p>Provide evidence that every shift is covered with at least one staff member who holds a current first aid certificate.</p> <p>60 days</p>

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

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

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

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

No data to display
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End of the report.