

Windsor House Board of Governors - Windsorcare

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

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

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

The specifics of this audit included:

Legal entity:	Windsor House Board of Governors
Premises audited:	Windsorcare
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 19 July 2018 End date: 20 July 2018
Proposed changes to current services (if any):	This audit has also included verifying the service as suitable to provide medical level care under their current hospital certification
Total beds occupied across all premises included in the audit on the first day of the audit:	77



Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Windsorcare service provides rest home, hospital and dementia level care for up to 81 residents. At the time of the audit there were 77 residents in total.

This certification audit was conducted against the relevant Health and Disability standards and the contract with the district health board. The audit process included a review of policies and procedures; the review of residents and staff files, observations and interviews with residents, relatives, staff, management and general practitioner. This audit has also included verifying the service as suitable to provide medical level care under their current hospital certification.

The service has a general manager who is responsible for operational management of the service. He is supported by a management team including a clinical manager (the role was vacant at the time of the audit), finance administration manager, contracted quality manager/RN and an HR/payroll manager.

This audit identified improvements required around; mandatory training attendance, care planning and neurological observations monitoring.

A continuous improvement has been awarded around the activity 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.		Standards applicable to this service fully attained.
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Windsorcare endeavours to ensure that care is provided in a way that focuses on the individual, values residents' quality of life and maintains their privacy and choice. The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) is visible within the facility and additional information about the code is readily available. Staff demonstrated an understanding of residents' rights and obligations. Written information regarding consumers' rights is provided to residents and families. Evidence-based practice is evident, promoting and encouraging good practice. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

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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Windsorcare has a current business plan and a quality and risk management programme that outlines objectives/goals. The quality process being implemented includes regularly reviewed policies, an internal audit programme and a health and a healthy and safety programme that includes hazard management. Quality information is reported to staff and quality and risk management meetings. Residents and relatives are provided the opportunity to feedback on service delivery issues at three monthly meetings

and via annual satisfaction surveys. There is a reporting process being used to record and manage resident incidents. Incidents are collated monthly and reported to facility meetings. Windsorcare has job descriptions for all positions that include the role and responsibilities of the position. There is an annual in-service training programme schedule in place. There is an annual performance appraisal process in place. The service has a documented rationale for determining staffing levels. Residents and family members report staffing levels are sufficient to meet resident needs.

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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There is an admission package available prior to or on entry to the service. The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family/whanau input. Care plans reviewed in resident records demonstrated service integration and had been evaluated at least six monthly. Resident files included interRAI assessments, medical notes by the contracted GP and visiting allied health professionals. Medication policies reflect legislative requirements and guidelines. Registered nurses and senior care givers responsible for administration of medicines complete education and medication competencies. The medicine charts reviewed meet prescribing requirements and were reviewed at least three monthly.

A team of diversional therapists implement and coordinate the activity programme for the residents at rest home, hospital and dementia level of care. The programme includes community visitors and outings, entertainment and activities and integrated activities that meet the individual recreational, physical, cultural and cognitive abilities and preferences for each consumer group. Residents and families report satisfaction with the activities programme. Residents' food preferences and dietary requirements are

identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. There are nutritious snacks available 24 hours.

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 are documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. The building holds a current warrant of fitness. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating and shade. Resident bedrooms are personalised with own ensuites or shared ensuites. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services. Documented systems are in place for essential, emergency and security services. There is at least one staff member on duty at all times with a current first aid certificate.

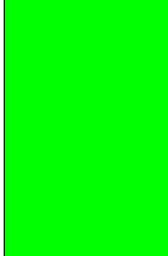
Restraint minimisation and safe practice

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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Windsorcare has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of

enablers. At the time of the audit there were four residents with enablers and eight restraints. Staff have received training on restraint minimisation and the management of challenging behaviours.

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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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There is a suite of infection control policies and guidelines to support practice. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. There have been no outbreaks.

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	1	46	0	2	1	0	0
Criteria	1	97	0	2	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. The policy relating to the Code is implemented and staff could describe how the Code is incorporated in their everyday delivery of care. Interviews with 15 care staff, including eight caregivers, three registered nurses (RN), one enrolled nurse (EN) and three diversional therapists, reflected their understanding of the key principles of the Code (link 1.2.7.5).</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>There are established informed consent policies/procedures and advanced directives. General consents were obtained on admission as sighted in the nine resident files reviewed (five hospital including one under an end of life contract, two rest home and two dementia care). Advance directives if known were on the resident files. Resuscitation plans were sighted in all files and were signed appropriately. Copies of EPOA were present and activated as required. An informed consent policy is implemented.</p> <p>Systems are in place to ensure residents, and where appropriate their family/whanau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Family and residents interviewed confirmed they have been made aware of and fully understand</p>

		informed consent processes and that appropriate information had been provided. All long-term resident's files reviewed had signed admission agreements on file. The resident representative had signed the district health board (DHB) end of life contract.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy support 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	Residents may have visitors of their choice at any time. The service encourages the residents to maintain relationships with their family, friends and community groups by encouraging their attendance at functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Resident/relative meetings are held every three months.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints procedure is provided to residents and relatives on entry to the service. Complaints forms are in a visible location at the entrance to the facility. The general manager maintains a record of all complaints, both verbal and written, by using a complaint's register. Twenty-one complaints/concerns made in 2017 and ten complaints/concerns received in 2017 year to date have been reviewed with evidence of appropriate follow-up actions taken. Documentation including follow-up letters and resolution demonstrated that complaints are being managed in accordance with guidelines set by the HDC. Any corrective actions developed are followed up and implemented. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at the entrance to the facility. A manager discusses aspects of the Code with residents and their family on admission. Discussions relating to the Code are held during the three-monthly resident/family meetings. Seven residents (four rest home and three hospital) and four relatives (one hospital and three dementia care) interviewed reported that the residents' rights are being upheld by the service. Interviews with residents and family also confirmed

		their understanding of the Code and its application to aged residential care.
<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	Residents are treated with dignity and respect. Privacy is ensured, and independence is encouraged. Discussions with residents and relatives were positive about the service in relation to their values and beliefs being considered and met. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. Staff have received training around abuse and neglect (Link 1.2.7.5).
<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	The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. At the time of the audit there were no residents that identified as Māori living at the facility. Māori consultation is available through the documented iwi links.
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. Residents and relatives interviewed confirmed they were involved in developing the resident's plan of care, which included the identification of individual values and beliefs.
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	A staff code of conduct is discussed during the new employee's induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is infringement with the person concerned.

<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service has policies to guide practice that align with the health and disability services standards. Policies and procedures are well established, cross referenced and reviewed regularly to ensure continuity of care. Windsorcare has a current business plan and a quality and risk management programme that outlines objectives/goals. There is an annual in-service training programme schedule in place (Link 1.2.7.5). Services are provided at Windsorcare that adhere to the Health and Disability Sector Standards. There is an implemented quality improvement programme that includes performance monitoring. There are implemented competencies for caregivers, ENs and RNs. There are clear ethical and professional standards and boundaries within job descriptions.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints and open disclosure policies alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. The information pack is available in large print and is read to residents who require assistance. An introduction to the dementia unit booklet provides information for family, friends and visitors visiting the facility.</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>Windsorcare service provides rest home, hospital and dementia level care for up to 81 residents. On the day of the audit there were 77 residents in total, including 19 of 20 rest home residents, 38 of 41 hospital level residents, including one resident on an end of life contract and 20 of 20 dementia care residents. All permanent residents were on the aged related residential care (ARRC) contract. This audit has also included verifying the service as suitable to provide medical level care under their current hospital certification. The service has policies and procedures that support providing medical level care. There is also links to allied health providers and support.</p> <p>The general manager has a PhD in management and has been in the role since June 2015. He is supported by a clinical manager, finance administration manager, contracted quality manager/RN and an HR/payroll manager. The clinical manager role provides clinical oversight at Windsorcare. However, at the time of the audit the clinical manager role was vacant due to the previous clinical manager leaving in May 2018. The manager is currently going through the recruitment process to employ a clinical manager. The contracted quality manager/RN is currently taking on the key duties of the clinical manager role. The quality manager is suitably qualified for the clinical manager role with</p>

		<p>many years' experience in aged care.</p> <p>The service is governed by the Windsor House board of governors (eight governors on the board). The board of governors meets monthly and receives reports on all aspects of service delivery at Windsorcare. The general manager reports to the monthly board of trustees meeting, confirmed by one of the board of governors interviewed. Windsorcare has a strategic plan and a quality and risk management programme in place for the current year. The organisation has a philosophy of care which includes a mission statement.</p> <p>The general manager and acting clinical manager have completed in excess of eight hours of professional development in the past 12 months.</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>The finance administration manager steps in when the general manager is absent. The finance administration manager is supported by the clinical manager, quality manager/RN and the care staff.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	FA	<p>Windsorcare has a current business plan and a quality and risk management programme that outlines objectives/goals. The quality and risk process being implemented includes regularly reviewed policies, an internal audit programme and a health and safety programme that includes hazard management. Quality and risk performance is reported across the facility meetings. Facility meetings include (but not limited to) staff, quality and risk management and clinical meetings. Meeting minutes sighted evidence there is discussion around quality data including complaints, compliments, health and safety, accident/incidents, infection control, internal audit and survey results. Staff interviewed state they are well informed and have ready access to meeting minutes. Monthly reports by the general manager to the Windsor House board of governors provide a coordinated process between service level and organisation.</p> <p>The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Discussion regarding policy development/revision occurs at staff, quality and risk management, clinical, health and safety/infection control meetings. Release of updated or new policy/procedure/audit/education occurs</p>

		<p>across the facility (sighted). Review of policies and documentation occurs on a two-yearly basis. There is an internal audit programme being implemented for 2018. Audit summaries and corrective action plans are completed where a non-compliance is identified. Issues are reported and discussed at the monthly quality and risk management meeting.</p> <p>Health and safety policies are implemented and monitored. The health and safety officer (HR/payroll manager) has completed external health and safety training (level one). The health and safety committee meet monthly. The meeting minutes evidence trends and analysis of accidents/incidents. The hazard register is up-to-date and was last reviewed on 3 July 2018. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. There is an annual satisfaction survey which was last completed in December 2017. Overall results report that residents and relatives are satisfied with the service. Corrective actions have been established in areas where improvements were identified, i.e. activities and food service. Corrective actions have been completed and signed off in March 2018.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accident/incident policy, which is part of the risk management and health and safety framework. Accident/incident data, trends and corrective actions are documented in meeting minutes sighted. Fifteen accident/incident forms (three rest home, ten hospital and two dementia care) were reviewed for May, June and July 2018. All incident forms identified timely RN assessment of the resident and corrective actions to minimise resident risk. However neurological observations had not been completed as per protocol for seven of ten reviewed unwitnessed falls and any known head injury (Link 1.3.6.1).</p> <p>The general manager interviewed could describe situations that would require reporting to relevant authorities. There have been two section 31 notification reported since the last audit, in relation to a stage four pressure injury in August 2017 and a stage three pressure injury in April 2018.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. The register of nursing practising certificates and allied health professionals is current. Ten staff files were reviewed (three RNs, four caregivers, one head cook, one maintenance person and one diversional assistant). All files contained relevant employment documentation including current performance appraisals and completed orientations. The orientation programme provides new staff with relevant information for safe work practice. Staff interviewed are able to describe the orientation process and believed new staff were adequately orientated to the service.</p> <p>The in-service education programme for 2017 has been completed and the 2018 programme is being implemented. However, staff attendance has been low at compulsory training and there was no</p>

		documented evidence of eight hours annual training being completed for all staff in 2017. Ten out of thirteen RNs have completed their interRAI training. InterRAI assessments and contractual obligations were being met. Staff complete competencies relevant to their roles. All 18 caregivers who work in the dementia care unit have completed the dementia unit standards.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is an organisational staffing policy that aligns with contractual requirements and includes skill mixes. A recently updated roster provides sufficient and appropriate coverage for the effective delivery of care and support. The general manager and acting clinical manager work full time from Monday to Friday. The general manager is available 24/7 for any operational or facility concerns and the acting clinical manager completes on-call requirement for any clinical issues. Residents and relatives state there were adequate staff on duty at all times. Staff interviewed feel that they are supported by the general manager and acting clinical manager who respond quickly to after hour clinical or facility concerns.</p> <p>In the hospital area, there are 38 of 41 hospital residents with two RNs on the morning and afternoon shifts and one on the night shift. The RNs are supported by eight caregivers (four long/four short shifts) on the morning shift, six caregivers (two long/four short shifts) on the afternoon shift, and three caregivers on the night shift.</p> <p>In the rest home area, there are 19 of 20 rest home residents with one RN (four-hour shift) on the morning shift. The RN is supported by three caregivers (two long/one short shifts) on the morning shift, two caregivers (full shift) on the afternoon shift, and one caregiver on the night shift.</p> <p>In the dementia care area, there is 20 of 20 dementia residents with one RN (four-hour shift) on the morning shift. The RN is supported by three caregivers (two long/one short shifts) on the morning shift, two caregivers (full shift) on the afternoon shift, and one caregiver on the night shift.</p> <p>The RNs in the hospital area oversee the rest home and dementia areas on the afternoon and night shifts.</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>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p>

<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. The service has an information folder for residents/families/whanau at entry on all levels of care including the dementia secure unit. Nine admission agreements reviewed align with all contractual requirements. Exclusions from the service are included in the admission agreement.</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>Planned exits, discharges or transfers were coordinated in collaboration with the resident and family to ensure continuity of care. There were documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families were involved for all exit or discharges to and from the service.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place for safe medicine management that meet legislative requirements. Clinical staff who administer medications (RNs, ENs and senior caregivers) have been assessed for competency on an annual basis. Education around safe medication administration has been provided. The caregiver was observed to be safely administering medications in the dementia unit. Medications are received in blister packs and checked by the RN against the medication chart. A medication reconciliation form is completed, and any discrepancies are fed back to the pharmacy. All medications are stored safely in one centralised medication room. A bulk supply order is maintained for hospital level residents. Registered nurses have completed syringe driver training and they are supported by the hospice for palliative care.</p> <p>All as required medications and impress stock is checked monthly for expiry dates. Restricted medications are checked as required by legislation. The medication fridge temperature is checked and recorded at least weekly. All eye drops were dated on opening. There were no residents self-medicating. All 18 medication charts reviewed met legislative prescribing requirements. The GP has reviewed the medication charts three monthly. All medications had been administered as prescribed. Medication errors are completed on the incident form and identified internal investigations, corrective actions (including repeated medication competencies) and discussion at clinical and management meetings. Corrective actions implemented has resulted in 90% reduction in errors from May to June 2018.</p>
<p>Standard 1.3.13: Nutrition, Safe</p>	FA	<p>All meals at Windsorcare are prepared and cooked on site. A head cook/kitchen manager is supported by a second cook and catering assistants. There is a six-weekly seasonal menu which had been</p>

<p>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>reviewed by a dietitian September 2017. The service has a food control plan issued 17 October 2017. There are two menu choices for the midday and evening meal. Dietary requirements and pureed meals are provided. Resident dislikes are known and accommodated. Cultural and religious food preferences are met. Meals are plated in the kitchen onto heated plates and covered with insulated lids and delivered by trolley to the dining rooms. Staff were observed assisting residents with their meals and drinks in the hospital and dementia care dining rooms. There were nutritional snacks available 24-hours in the dementia care unit.</p> <p>End cooked food temperatures, re-heating and serving temperatures are taken recorded on each meal. Fridge, freezer and chiller temperatures are taken and recorded daily. Temperatures of inward goods are recorded. The dishwasher is checked regularly by the chemical supplier. All food services staff have completed training in food safety and hygiene and chemical safety. A kitchen cleaning schedule is in place and implemented. Dried goods and perishable foods are dated. Resident meetings and surveys, along with direct input from residents, provide resident feedback on the meals and food services generally. The head cook serves desserts in the dining rooms and is available for feedback. She also attends the resident meetings. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were offered for dislikes.</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 an admission information policy. The reasons for declining entry would be if the service is unable to provide the care required or there are no beds available. Management communicate directly with the referring agencies and family/whanau as appropriate if entry was declined.</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 RN completes an initial assessment on admission including applicable risk assessment tools. A first interRAI assessment is undertaken within 21 days of admission and routinely six monthly, or earlier due to health changes. Resident needs and supports are identified through the on-going assessment process in consultation with significant others. The information gathered on admission including medical notes, discharge summaries and discussion with significant others forms the basis for the care planning.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans</p>	PA Moderate	<p>Resident care plans reviewed were individualised, however not all care plans reflected current supports to meet all assessed resident needs. Caregivers interviewed stated the care plans provided enough</p>

<p>are consumer focused, integrated, and promote continuity of service delivery.</p>		<p>information to guide the safe delivery of care. Care plans evidenced resident (as appropriate) and family/whanau involvement in the care plan process. There were 24-hour activity plans for residents with dementia that included morning, afternoon and night time habits/behaviours and de-escalation techniques including activities. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrate service integration.</p> <p>There was evidence of allied health care professionals involved in the care of the resident including physiotherapist, dietitian, palliative care nurse, community geriatrician and gerontology nurse specialist and older person mental health service.</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>	<p>PA Low</p>	<p>When a resident's condition alters, the RN initiates a review and if required, GP, dietitian or nurse specialist consultation. Discussions with families and notifications are documented in the resident files in the relative contact form. Adequate dressing supplies were sighted in treatment rooms. Wound management policies and procedures are in place. Wound assessments, treatment and evaluations were in place for all current wounds, pressure injuries and skin tears. Change of dressings and evaluations had occurred at the required frequency. There were 10 residents with facility acquired pressure injuries (five stage two and six stage one). Short-term care plans were in place for wounds and chronic wounds were linked to the long-term care plans. Chronic wounds have been linked to the long-term care plans.</p> <p>There was photographic evidence of wound healing. There was documented evidence of allied health input into wound healing. The three RNs interviewed confirmed there was a range of equipment was readily available to minimise pressure injury and was sighted to be in use for those residents at risk. There is access to a wound nurse specialist as required. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Residents are weighed monthly or more frequently if weight is of concern. Nutritional requirements and assessments are completed on admission identifying resident nutritional status and preferences. Monitoring occurs for weight, vital signs, blood glucose, pain, food and fluid intake, two hourly positioning, and challenging behaviours. Neurological observations had not been completed for all unwitnessed falls reviewed and one resident did not have blood pressures recorded.</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,</p>	<p>CI</p>	<p>The service employs three qualified diversional therapists (DT) who develop and implement the separate activity programme for the rest home, hospital and dementia unit. The programme identifies integrated activities that all residents are invited to attend in the entertainment room such as bowls, entertainment, exercises, movies and ice-cream, happy hour, inter-home visits and competitions. Each area also has activities that are meaningful and meet the resident preferences, physical and cognitive</p>

<p>age, culture, and the setting of the service.</p>		<p>abilities of the resident group. Volunteers are involved in the activities and include piano players, one on one visiting and chats, board games, church services, pre-schoolers, high school children, Duke of Edinburgh students and weekly canine therapy. One on one activities such as individual walks, massage, reading, arts and crafts occur for residents who are unable or choose not to be involved in group activities. The dementia care programme is flexible around the residents needs and include sensory activities such as baking, gardening and crafts.</p> <p>The caregivers ensure residents have the opportunity to attend set activities in the weekends. There are regular outings and drives for all residents (as appropriate). The service has a van and a mobility van is hired for monthly hospital level residents. The DTs have current first aid certificates. An activity assessment and plan are completed on admission in consultation with the resident/family (as appropriate). Activity plans in all files were reviewed six monthly. Families are invited to the resident meetings. The service also receives feedback and suggestions for the programme through surveys and one on one feedback from residents (as appropriate) and families. Residents and families interviewed were very satisfied with the activities offered.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All initial care plans reviewed were evaluated by the RN within three weeks of admission. Long-term care plans had been reviewed at least six monthly or earlier for any health changes for long-term residents. Evaluations documented if the resident goals had been met or unmet and changes made by the RN to reflect the resident's current needs/supports. The resident (as appropriate) and family are involved in the multidisciplinary review. The GP reviews the residents at least three monthly or earlier if required. On-going nursing evaluations occur as indicated and are documented within the progress notes and are evident in changes made to care plans (Link 1.3.5.2).</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) 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>Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. There is evidence of referrals for re-assessment of level of care. There are documented policies and procedures in relation to exit, transfer or transition of residents. The residents and the families are kept informed of the referrals made by the service.</p>
<p>Standard 1.4.1: Management Of</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place to ensure</p>

<p>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>incidents are reported in a timely manner. Material safety data sheets and product are readily accessible for staff in the sluice rooms, laundry and cleaning cupboards. Chemical bottles sighted have correct manufacturer labels. Chemicals are stored in locked areas. A chemical spills kit is available. Personal protective clothing is available for staff and seen to be worn by staff when carrying out their duties on the day of audit.</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>The building has a current building warrant of fitness that expires 1 January 2019. The service employs a full-time maintenance person who has a background in building. The gardens and grounds are maintained by contractors. A request list is completed for any maintenance and repairs and entered into a computer data base. An annual planned maintenance schedule is maintained and includes maintenance for internal and external areas, kitchen, laundry and clinical areas. Annual testing and tagging of electrical equipment has been completed and calibrations of medical equipment. Essential contractors are available 24 hours. Hot water temperatures in resident areas are monitored two monthly. Rooms are refurbished as they become vacant.</p> <p>The rest home, hospital and dementia unit have been renovated with soft furnishings, painting, art work and replacement of carpet in the dementia unit. An automatic irrigation system has been set up in the dementia unit gardens and outdoor seating has been placed around the facility. The facility has wide corridors with sufficient space for residents to safely mobilise using mobility aids. There is to safe access the outdoor areas. Seating and shade is provided. The dementia unit has an indoor/outdoor flow with pathways and entry/exits into two courtyards with gardens shade and seating. The caregivers and RNs interviewed stated they have sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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>Toilet and shower facilities are of an appropriate design to meet the needs of the residents. There are a mix of rooms with ensuites and some with shared ensuites with privacy locks and shower curtains. Communal toilet facilities have a system that indicates if it is engaged or vacant. Residents interviewed confirmed care staff ensure their privacy is met when attending to hygiene cares.</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>	FA	<p>At present all rooms are used as single. There is adequate room to safely manoeuvre mobility aids and transferring equipment such as hoists in the resident bedrooms. Residents and families are encouraged to personalize their rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas within the facility include a lounge and dining room in each area along with additional smaller lounges/family rooms with tea/coffee making facilities in the rest home and hospital. There is a large shared entertainment room where many integrated activities take place. Seating and space is arranged to allow both individual and group activities to occur. All furniture is safe and suitable for the residents. There are several seating alcoves within the facility. There is safe access to the communal areas and outdoors. The dementia unit resident have free access (weather permitting) to the safe outdoor 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>	FA	<p>There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. There are dedicated laundry and cleaning staff seven days a week. The laundry has defined clean/dirty areas with an entry and exit door. Internal audits and the chemical provider monitor the effectiveness of the cleaning and laundry processes. Equipment is serviced six monthly. The cleaning trolley is kept in a locked cupboard when not in use. There is a chemical mixing dispenser located in the laundry. Adequate personal protective clothing was available for use.</p> <p>Residents and family interviewed reported satisfaction with the cleaning and laundry service.</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>	FA	<p>There is an emergency action plan in place to guide staff in managing emergencies and disasters. Fire training, emergency evacuation, first aid and CPR are included in the mandatory in-service programme. At least one staff member is on duty at all times with a current first aid certificate. There is a RN on site available to all residents 24/7. Fire evacuation drills take place every six months, with the last fire drill occurring on 16 May 2018. The NZ Fire Service approved the evacuation scheme on 11 August 2011. Smoke alarms, sprinkler system and exit signs are in place. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>The service has alternative gas facilities (BBQ and gas hobs in the kitchen) for cooking in the event of a power failure. The service also has a generator on site for emergency lighting and battery backup. Civil defence and pandemic/outbreak supplies are available in and are checked regularly. There is food</p>

		stored in the kitchen for three days. There is sufficient water stored (water) to ensure for three litres per day for three days per resident. There are call bells in all communal areas, toilets, bathrooms and residents rooms. Security policies and procedures are documented and implemented by staff. Visitors and contractors sign in when visiting the facility.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. The heating in each room can be individually controlled. There are sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to promote ventilation and to be secured as needed.
Standard 3.1: Infection control management 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.	FA	The infection control coordinator (acting clinical manager) oversees infection control for the facility and is responsible for the collation and reporting of infection events. Infection events are collated monthly for each of the areas (rest home, hospital and dementia care) and reported to the quality and risk management meeting and infection control committee. Infection control is a standard agenda topic at facility meetings. Meeting minutes are available to all staff for reading. The 2017 infection control programme has been reviewed November 2017 and is linked to the quality system. Visitors are asked not to visit if unwell. Hand sanitizers are appropriately placed throughout the facility. Residents are offered the influenza vaccine.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has completed a half study day with Southern Community Laboratory in January 2017. The infection control coordinator and committee (RNs, enrolled nurses, general manager, caregivers, cleaning and housekeeping and administrator staff) have access to GPs, local Laboratory, the infection control nurse specialist and public health departments at the local DHB for advice and an external infection control consultant specialist (Bug Control). The infection control coordinator receives updates and has access to relevant websites with up to date information.
Standard 3.3: Policies and procedures Documented policies and	FA	The infection control policies include a comprehensive range of standards and guidelines including defining roles and responsibilities for the prevention of infection, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate

<p>procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>the principles of infection control. The policies are developed by an external consultant (Bug Control) and are reviewed regularly.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Training on infection control is included in orientation and as part of the annual training schedule. Hand hygiene competencies are completed on orientation and are ongoing. Annual infection control education was provided for all staff May 2018. Resident education is expected to occur as part of providing daily cares as appropriate.</p>
<p>Standard 3.5: Surveillance 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>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports and short-term care plans are completed for all infections. Infection control data and relevant information is displayed for staff. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is discussed at both the quality and risk management and infection control committee meetings. Annual infection control reports are provided. Trends are identified, and preventative measures put in place. Internal audits for infection control including kitchen, cleaning and clinical care are included in the annual audit schedule. There is close liaison with the GP that advises and provides feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. There have been no outbreaks since the last audit.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Windsorcare has a restraint minimisation policy. Restraint practices are only used where it is clinically indicated and justified, and other de-escalation strategies have been ineffective. The policies and procedures include definitions, processes and use of enablers. At the time of the audit there were four residents using enablers (two bed loops and two lap belts) and eight residents with eight restraints. Restraint/enablers are reviewed monthly at the quality and risk management meeting. Staff have</p>

		received training on restraint minimisation and the management of challenging behaviours.
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	The restraint coordinator is a RN who has been in the role for over five years. Restraint and consent is in consultation/partnership with the resident (as appropriate) or family member, the restraint coordinator, GP and an RN. Assessments identify specific interventions or strategies to try (as appropriate) before use of restraint. Alternative strategies are documented on the behaviour chart of a resident with challenging behaviour. Restraint use is considered as a last resort and only implemented in consultation with the family and where resident safety is compromise.
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	Restraint assessments are undertaken by the restraint coordinator in partnership with the resident and their family. Restraint assessments are based on information in the initial care assessment, long term care plan, resident/family discussions, RN and care staff observations, accident or incidents, review of clinical risk assessment tools and behaviour assessments. Three of three resident files reviewed of residents with restraint evidenced a restraint risk assessment, consent form and three-monthly evaluations. The completed assessments considered those listed in 2.2.2.1 (a) - (h).
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	The service has an approval process (as part of the restraint minimisation policy) that is applicable to the service. The restraint coordinator is responsible for completing all the documentation. The approval process includes ensuring the environment is appropriate and safe. Restraint use is reviewed monthly within the quality and risk management meeting and also as part of monthly restraint register reviews. Any restraint incidents are discussed at this meeting and corrective actions initiated. Care plans reviewed of three of three residents with restraint identified observations and monitoring.
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluations are completed by the restraint co-ordinator at least three monthly or earlier if required. A review of three resident files identified that evaluations are up-to-date.

<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>Individual approved restraint is reviewed at least three monthly as part of the medical review with the resident/family/whanau as appropriate. Restraint usage is monitored regularly by the restraint coordinator. Corrective actions are monitored. Restraint is discussed at the quality and risk management and clinical meetings. Individual restraint use is monitored and recorded by staff.</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 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Low	The in-service education programme for 2017 has been completed and the 2018 programme is being implemented. However, staff attendance has been low at compulsory training and there was no documented evidence of eight hours annual training being completed for all staff in 2017.	Staff attendance numbers at compulsory trainings has remained low in 2017 and 2018 year to date. For example, 18 of 97 staff attended the code of rights and privacy/dignity training, 17 of 97 at the complaints/advocacy training and 19 of 97 at the abuse and neglect training. While staff training records are maintained, there was no documented evidence of how staff that have not attended compulsory training are followed up to ensure they complete.	<p>staff that have not completed are followed up.</p> <p>90 days</p>
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the</p>	PA Moderate	Seven of nine care plans reflected the resident's current health status and outcomes of assessments.	i) The care plan had not been updated to reflect changes in behaviour and interventions for one dementia care resident. The same resident did not have any interventions	Ensure care plans reflect the resident

required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.			documented for unintentional weight loss, and ii) there were no documented interventions for another dementia care resident with changes in behaviour.	current health status, supports and interventions. 90 days
Criterion 1.3.6.1 The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes.	PA Low	There are a number of monitoring forms used to monitor a resident's health status. Monitoring forms are reviewed by the RN and interventions updated on care plans or short-term care plans developed and reviewed regularly. Not all required interventions had been implemented.	i) Neurological observations had not been completed as per protocol following seven of ten unwitnessed falls reviewed and ii) the blood pressure for one resident with postural hypotension had not been completed for two consecutive months.	Ensure monitoring occurs as required. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.3.7.1</p> <p>Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.</p>	CI	The service implemented a quality initiative following their satisfaction survey around activities for residents	The service has engaged the Clown Doctors the last four months to actively connect with residents in the hospital area. Feedback reviewed provided by residents and relatives that identify the Clown Doctors have been a positive interaction with residents and how beneficial the clown doctors are and how they add value, and meaning to their daily lives. The service also installed WIFI throughout the facility (April 2017). Numerous residents and their families have thanked Windsorcare for being able to connect to the internet and communicate in a timely manner with family and friends. Staff also assist and educate residents on how to access the internet and also to communicate with family.

End of the report.