Aspen Lifecare Limited- Aspen

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:	Aspen Lifecare Limited
Premises audited:	Aspen
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 25 July 2018 End date: 26 July 2018

Proposed changes to current services (if any): This audit included verifying three additional beds to increase the number of beds from 54 to 57

Total beds occupied across all premises included in the audit on the first day of the audit: 47

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

General overview of the audit

Aspen Lifecare provides rest home and hospital level care for up to 57 residents. At the time of the audit there were 47 residents in total. The residents, relatives and general practitioner commented positively on the care and services provided at Aspen Lifecare.

This certification audit was conducted against the relevant Health and Disability Standards and the contract with the district health board. The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a general practitioner.

The service is managed by a facility manager who has been at Aspen Lifecare since January 2018 and has worked in the aged care sector in clinical and facility management roles for over 20 years. She is supported by a clinical services manager and an administrator.

This audit identified the following areas for improvement around admission agreements, quality programme, mandatory education/training, timeframes, care plan interventions, wound documentation, activities plan/assessment, and infection control nurse training.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Some standards applicable to this service partially attained and of low risk.

The facility provides care in a way that focuses on the individual resident. There is a Māori health plan and cultural safety policy supporting practice. The service functions in a way that complies with the Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services is readily available to residents and families. Policies are available that support residents' rights. The complaints policy and procedures are implemented, and complaints and concerns are managed and documented. Residents and family interviewed verified ongoing involvement with community.

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.

There is a quality assurance and risk management programme being implemented. Progress with the quality assurance and risk management programme is designed to monitor contractual and standards compliance and to ensure that residents receive care in the best possible way. Residents and families are surveyed annually. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. Appropriate employment processes are adhered to and all employees have an annual staff performance appraisal completed. The service has an orientation programme in place that

provides new staff with relevant information for safe work practice. There is a documented annual in-service education schedule. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.

The registered nurse is responsible for each stage of service provision. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau. The residents' each have a care plan, and these are reviewed at least six-monthly or earlier if there is a change in health status. The activity programme is developed to promote resident independence and social interaction. Residents interviewed spoke positively about the activity programme. Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies and medications are stored appropriately. Food services and meals are prepared on-site. There has been a dietitian review of the menu. All kitchen staff have been trained in food safety and hygiene.

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.

The building has a current warrant of fitness. Chemicals were stored safely throughout the facility. All bedrooms are single occupancy with hand basins. An adequate number of toilet and shower facilities are available to meet the residents needs, there is also one shared ensuite between two resthome rooms. There are separate toilets available for both visitors and staff. There is sufficient space to allow the movement of residents around the facility. The hallways and communal areas are spacious and accessible. The outdoor areas are easily accessible. Housekeeping staff maintain a clean and tidy environment. All laundry services are managed on-site. Hot water temperatures have been checked and recorded regularly. A civil defence/emergency plan is documented for the service. There is a 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.

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. On the day of audit there were two residents using restraints and no residents with an enabler. The restraint standards are being implemented and implementation is reviewed through meetings. Interviews with the staff confirm their understanding of restraints and enablers. Restraint assessments link to care plans. The service has an approval process that is applicable to the service. A restraint register is in place

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Some standards applicable to this service partially attained and of low risk.

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 nurse has attended external education and coordinates education and training for staff. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner. Infection prevention and control is integrated into full staff and registered nurse meetings. There is a suite of infection control policies and guidelines to support practice.

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	42	0	5	3	0	0
Criteria	0	93	0	5	3	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
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Discussions with seven care staff (four HCAs, one registered nurse (RN), one cook and one diversional therapist) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Five residents (three rest home and two hospital) and four relatives (one rest home and three hospital) were interviewed and confirmed the services being provided are in line with the Code. Observation during the audit confirmed this in practice.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low	Informed consent processes are discussed with residents and families on admission. Written consents were all signed correctly. There is evidence of discussion with family when the general practitioner (GP) has completed a clinically indicated not for resuscitation order. Health care assistants and RNs interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relative's lives. Not all of the seven resident files sampled had a signed admission agreement on file.
Standard 1.1.11: Advocacy And	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy

Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.		pamphlets are available at reception. Discussions with relatives confirmed the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks.
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 and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes include opportunities to attend events outside of the facility including activities of daily living, for example, going shopping, and attending cafés and restaurants. Interview with staff, residents and relatives informed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedures are implemented and residents and their family/whānau are provided with information on admission. The residents and families interviewed were aware of the complaints process and to whom they should direct complaints. There are complaint forms available throughout the facility. Staff interviewed described the process around reporting complaints. There is a complaint register. Verbal and written complaints are documented. There were ten complaints made in 2017 and nine complaints received in 2018 year to date. The complaints documentation reviewed included an investigation, corrective actions when required and resolutions. Two of the complaints received in 2017 were made through the district health board (DHB) in April 2017 and Health & Disability Commissioner (HDC) in September 2017. Both complaints were investigated, resolved and included corrective actions for any required improvements.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed identified they are well informed about the Code. Three monthly resident/relative meetings provide the opportunity to raise concerns. An annual resident/relative satisfaction survey is completed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect	FA	Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Residents and relatives interviewed reported that residents can

Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.		choose to engage in activities and access community resources. There is an abuse and neglect policy, however staff education and training on abuse and neglect has not been provided in the past two years (link 1.2.7.5).
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Aspen Lifecare has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of audit there were two residents who identified as Māori. A review of the resident files identified involvements in specific Māori community events as requested by the resident. Māori consultation is available through staff employed and the local Maungatapu Church. Staff interviewed could describe how they can ensure they meet the cultural needs of Māori.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Discussion with relatives confirmed values and beliefs are considered. Residents interviewed confirmed that staff consider their culture and values.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities and staff sign a copy on employment. The staff meeting occurs three monthly and includes discussions on professional boundaries and concerns as they arise. Management provide guidelines and mentoring for specific situations. Interviews with the facility manager, acting clinical services manager, RNs and HCAs confirmed an awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. Staffing policies include pre-employment, and the requirement to attend orientation and ongoing in-service training. The facility manager is responsible for coordinating the internal audit programme. Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and stated that they feel supported by the facility manager, acting clinical services manager and the RNs. Care staff complete competencies relevant to their practice.

		The service has been transitioning to the CAVELL Group policies and procedures. In 2018, they have reviewed all systems and implemented a new IT system. The service has been recruiting new staff and establishing monthly training days so all staff can go through and have refreshers for existing staff (link 1.2.7.5). Registered nurses have a Primary Care Group of residents and they work with Nurse Practitioner for assessment and guidance with complex residents
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alert staff to their responsibility to notify family/next of kin of any accident/incident. Fifteen incidents/accident forms were reviewed for July 2018. The forms included a section to record family notification. The incident/accident forms indicated family were informed or if family did not wish to be informed. Family members interviewed confirmed they are notified of any changes in their family member's health status.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Aspen Lifecare is a privately-owned facility, owned by a board of directors (Buttermilk Residential Care Limited). Aspen Lifecare provides rest home and hospital level care (medical and geriatric services) for up to 57 residents. This audit included verifying an additional three beds (one rest home and two dual-purpose). These rooms were verified as suitable for purpose. They extra rooms increase the number of beds from 54 to 57 (as per a HealthCERT reconfiguration letter dated 28 February 2018). There are 12 designated rest home beds and 45 beds for dual-purpose use. At the time of the audit there were 47 residents in total, 28 residents requiring rest home level care including one resident on a long-term support chronic health condition (LTS-CHC) contract and three residents on respite care. There were 19 residents requiring hospital level care including one resident on a LTS-CHC contract and one resident on respite care. Aspen Lifecare has a business plan (1 April 2018 to 31 March 2019) in place. The annual review for the 2017/2018 business plan was completed at the end of April 2018. The facility manager reports monthly to the board of directors on a variety of matters. The service is managed by a facility manager who is an RN and has worked in the aged care sector in clinical and facility management roles for over 20 years. She has been at Aspen Lifecare since January 2018. The facility manager reports to the board of directors. She is supported by an acting clinical services manager (at the time of the audit the clinical services manager role was vacant with the recruitment process underway) and an administrator. The acting clinical services manager (senior RN) who has been in the position since the 12 of July 2018 and has worked at Aspen Lifecare for three years.

		The facility manager has completed at least eight hours of professional development activities related to managing an aged care facility.
Standard 1.2.2: Service Management 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.	FA	During a temporary absence, the clinical services manager covers the facility manager's role, with the support from the directors and care staff.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	Aspen Lifecare has a documented quality and risk management system. The facility manager's monthly report to the board of directors covers staffing, resident occupancy, quality improvement activities, accident/incident data and any complaints/compliments. There are policies and procedures implemented to provide assurance that the service is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. The service is in the process of changing over to the CAVELL policies and procedures. Staff interviewed confirmed they are made aware of new/reviewed policies. Quality data trends analysis related to incidents and accidents, infection control, restraint and complaints is completed. However, there was no documented evidence that staff meeting minutes included discussion around quality data trends analysis and what actions were required by staff. Management meetings are held regularly, and staff meetings are held three monthly. There is an annual internal audit calendar in place, however not all internal audits for 2017 and 2018 have been completed as per the required schedule. There is a health and safety and risk management system in place including policies to guide practice. Health and safety is discussed at the three-monthly health and safety and staff meetings. Hazard identification forms are completed for any accidents or near misses and there was a documented hazard register in place, last updated in July 2018. The resident/relative satisfaction survey was completed in July 2017, however there was no overall analysis available at the time of the audit due to the change in ownership. Fall prevention strategies are in place that include the analysis of falls accident/incidents and the identification of interventions on a case-by-case basis to minimise future falls.

Standard 1.2.4: Adverse Event Reporting 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.	FA	There is an accidents and incidents reporting policy. The facility manager investigates accidents and near misses and analysis of incident trends occurs. However, there is no documented evidence that there is a discussion of incidents/accidents data at staff meetings (link 1.2.3.6). Documented clinical follow-up of residents in the 15 incident forms reviewed did not consistently demonstrate wound assessments being completed and neurological observations had not been completed as per protocol for five of eight reviewed unwitnessed falls and any known head injury (link 1.3.6.1). Discussions with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. There have been 14 section 31 notifications required since the last audit. There were five pressure injuries notified, four stage three pressure injuries, one in September 2017, one in July 2017 and two in June 2017 and one stage four pressure injury in December 2017. Four police investigations, one in June 2017, two in August 2017 and one in September 2017. The other five notifications were for two missing residents in October 2017 and March 2018, two floods in October 2018 and July 2018 and one norovirus outbreak in November 2017.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are human resource management policies in place, that include that the recruitment and staff selection process require that relevant checks are completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one facility manager, acting clinical services manager, one RN, two HCAs, one kitchen manager/cook and one diversional therapist). These evidence appropriate employment practices including that reference checks were completed before employment was offered. The service has an orientation programme in place that provides new staff with relevant information to meet the needs of the residents. There is an annual in-service training calendar schedule, however there was no documented evidence of mandatory two-yearly training being completed for cultural awareness/safety, abuse and neglect, code of rights, advocacy, open disclosure, complaints, spirituality, nutrition/hydration, pain management and care planning. There are currently seven RNs working at Aspen Lifecare and six are interRAI trained.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or	FA	A policy is in place for determining staffing levels and skills mix for safe service delivery. Staff ratio mix was reviewed during the organisational structure change to reflect the needs of the residents. There is always an RN on duty 24/7. There is a long-standing consistent HCA team available. The facility manager is available on call at all times. Interviews with residents and family members identified that staffing is adequate to meet the needs of residents. The HCAs interviewed stated that they have sufficient staffing levels. The facility is split into two wings. The hospital wing has 26 dual-

experienced service providers.		purpose beds and the rest home wing has 19 dual-purpose beds and 12 designated rest home beds. In the hospital wing there were 24 residents in total, 18 hospital residents and six rest home residents. There is one RN on duty on the morning and afternoon shifts and one on the night shift. The RNs are supported by four HCAs on duty on the morning shift, three HCAs on the afternoon shift and one on the night shift. In the rest home wing there were 23 residents in total, 22 rest home residents and one hospital resident. There is one enrolled nurse (EN) on duty on the morning and afternoon shifts. The RNs are supported by three HCAs on duty on the morning shift, two HCAs on the afternoon shift and one on the night shift.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Other residents or members of the public cannot view sensitive resident information. Resident files are protected from unauthorised access by being held in a locked office. There is an allied health section that contained general practitioner notes and the notes of allied health professionals and specialists involved in the care of the resident.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Information packs are provided for families and residents prior to admission. Admission agreements reviewed align with contractual requirements (link 1.1.10.4). Exclusions from the service are included in the admission agreement.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. The facility uses the transfer from hospital to residential (yellow) aged care envelope that works in reverse when residents are transferred to a DHB acute hospital. Relatives are notified if transfers occur.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that	FA	There are policies and procedures in place for safe medicine management that meet legislative requirements. The RNs, ENs and senior HCAs who administer medications complete annual medication competencies. Annual in-service education on medication is provided by the supplying pharmacist. Medications (robotic rolls) are checked on delivery against the medication chart and any discrepancies fed back to the pharmacy. All medications are stored safely in the two nurses' stations.

complies with current legislative requirements and safe practice guidelines.		Standing orders are in use and meet the medication administration guidelines. There was one self-medicating resident who had a self-medication competency completed and reviewed three monthly by the GP. The medication fridge is monitored daily. Not all eye drops were dated on opening. Thirteen electronic and one paper-based medication charts were reviewed. All medication charts had photo identification and an allergy status. The GP reviews the medication charts at least three monthly. The electronic administration signing sheets reviewed identified medications had been administered as prescribed. Prescribed 'as required' medications include the indication for use. The doses and time given is signed for on the administration sighing sheet. Pain monitoring forms record the effectiveness of pain relief.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All baking and meals are cooked on-site at Aspen Lifecare by one chef and one cook with the assistance of two kitchenhands. Both the chef and cook, and kitchenhands have completed food handling through orientation and via external national programmes. The kitchen is spacious and includes areas for food preparation, cooking, baking, serving and cleaning areas. There are three fridges and two freezers. Kitchen fridge/freezer temperatures and food temperatures are monitored at least daily. Corrective actions for temperatures outside of range are documented and re-tested. Food stored in the fridge and chillers is covered and dated. The summer and winter menus are reviewed two-yearly by an external consultant dietitian. There is access to a community dietitian. Food is served directly to residents in the dining room and plated food is delivered in a hot box to residents not eating in the main dining area. Cooked/served food temperatures are completed prior to transport and completed before serving as part of the internal audit programme. Dry goods are stored in dated sealed containers in the pantry and kept off the ground. Chemicals are stored safely. Cleaning schedules were sighted and maintained. The service has a food plan registered with MPI (1 April 2018) and is awaiting a site audit April 2019. Aspen Lifecare has an organisational process whereby all residents have a nutritional profile completed on admission, a copy of which is provided to the cook, who is also notified (daily where necessary) of any dietary changes, weight loss or other dietary requirements. Special diets such as diabetic desserts, vegetarian, pureed and alternative choices for dislikes are accommodated. There are lists maintained within the kitchen of the resident's key alerts regarding allergies or food dislikes/preference for staff reference. Special equipment such as 'lipped plates' and built-up spoons are available as required. Residents/relatives interviewed, spoke positively about the food provided.

Standard 1.3.2: Declining Referral/Entry To Services 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.	FA	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/whānau as appropriate, if entry was declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Files sampled indicated that appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate, however not all residents had current assessments on file (link 1.3.3.3). The interRAI assessment tool is being implemented and there are six RNs competent to use the tool. Two of seven files sampled did not require a completed interRAI assessment on the day of audit (one resident recently admitted and one respite resident).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a range of template headings. The interRAI assessment and other assessments tools undertaken do not always inform the development of the resident's care plan. Residents and their family/whānau interviewed reported that they are involved in the care planning and review process. Staff interviewed reported they found the long-term care plans easy to follow. Short-term care plans are not always documented for a change in health condition.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	PA Moderate	Registered nurses and HCAs follow the care plan and report progress against the care plan each shift at handover. If external nursing or allied health advice is required, the RN will initiate a referral (eg, to the district nurse, or wound specialist nurse). If external medical advice is required, this will be actioned by the GP. Adequate dressing and medical supplies were sighted in the treatment rooms on the day of audit and staff interviewed reported they have access to sufficient dressings and syringes when they were required. Sufficient continence products are available and resident files include a continence assessment (link 1.3.4.2). Specialist continence advice is available as needed and this could be described. At the time of audit, there were thirty-four wounds involving 19 residents. In the hospital there were twenty wounds involving 13 residents. This included eight skin tears, eight ulcers or lesions and three pressure injuries. In the rest home there were fourteen wounds (seven residents including one resident with seven chronic ulcers and others including two skin tears, two skin fold excoriations, one surgical lesion, a graze and a haematoma. In addition, there was one stage-three pressure injury (non-facility acquired)

		and two stage two pressure injuries in a hospital level care resident. A sample of 20 wounds were reviewed as part of this audit. Not all wound documentation was fully completed as required and not all wounds have been reviewed in appropriate timeframes. On the day of audit, wound management plans were separated and re-documented into individual assessment and management plans. Interviews with the RNs and HCA demonstrated an understanding of the individualised needs of residents. There was evidence of pressure injury prevention interventions such as turning charts, food and fluid charts, regular monitoring of bowels and regular (monthly or more frequently if required) weight management.
Standard 1.3.7: Planned Activities 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.	PA Low	An activity coordinator is employed from seven hours a day Monday to Friday to coordinate and implement an activity programme that meets the recreational needs of the resident groups. The activity coordinator has experience as an HCA at Aspen Lifecare and has been in the role for four months. She attends on-site in-service and is enrolled in the Careerforce diversional therapy programme. Activities take place in the lounges and follow a documented programme. Residents from all areas are encouraged to attend the daily programme. Activities are meaningful and include (but are not limited to); exercises to music, crafts, bowls. quiz's, cooking, painting and art. Entertainment occurs in the weekends. There are visiting churches, library, grammar school students and pet therapy. All festivities and birthdays are celebrated. Outings into the community include shopping, picnics and outings to the local RSA for lunch. Residents are supported to attend their own church and other community functions. The activity coordinator is aware of the need to meet the requirements of the two younger persons and is working with them to maintain their community links and to provide meaningful activities such as assisting with the activities or tasks within the facility and grounds. A resident activity assessment is completed on admission. Each resident has an individual activity plan which is reviewed six monthly. The service receives feedback on activities through one-on-one feedback, residents' meetings and surveys. Residents and family interviewed confirmed participation is voluntary. Activities assessments and care plans are documented, however not all residents had a social/activities assessment completed on admission. Individual activities care plans and goals are developed. A record of individual attendance at activities is documented. Residents from all areas were partaking in activities during the audit.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive	FA	The RNs evaluate all initial care plans within three weeks of admission. Files sampled demonstrated that the long-term care plans were not all evaluated at least six monthly or earlier if there was a change in health status (link 1.3.3.3). Evaluations were documented and stated either that goals were achieved or not achieved, and progress documented. The RN completing the care plan signs the

and timely manner.		care plan reviews. Short-term care plans sighted were evaluated and resolved or added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled.
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.	FA	The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. Staff provided examples of where a resident's condition had changed, and the resident was referred for a change in care level. Wound referral recommendations and treatments were not always documented in the wound management plan (link 1.3.6.1).
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are policies in place for waste management, waste disposal for general waste and medical waste management. There are approved sharps containers in use for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals and chemicals in use are stored securely on the cleaner's trolley. Laundry and sluice rooms are locked when not in use. Material safety datasheets are available in all key areas. The hazard register identifies hazardous substances. Gloves, aprons and goggles are available in key areas for staff. Staff receive education on chemical safety. Interviews with HCAs described management of waste and chemicals, infection control policies and specific tasks/duties for which protective equipment is to be worn (as observed).
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	Aspen Lifecare provides rest home and hospital level care. There are several communal areas provided for both groups and individuals. The interior of the building is maintained with a home-like décor and furnishings. Residents were observed to safely mobilise throughout the facility. The service displays a current building warrant of fitness which expires 26 February 2019. Hot water temperature checks are conducted and recorded monthly by the maintenance person and maintained at 45 degrees Celsius. The service utilises hoists for resident transfer; these are calibrated and have electrical checks annually. The facility has a van for transporting residents. The registration expires on 19 August 2018 and the warrant of fitness on 15 August 2018. There is sufficient medical equipment to meet resident needs, including: pressure relieving mattresses; shower chairs – including a recently purchased reclining shower chair; wheelchairs; walking frames; hoists; heel protectors; transferring aids; chair scales; blood pressure machine and

		thermometers. There are several quiet seating nooks throughout the facility providing quiet low stimulus areas and privacy for residents and visitors. There is easy access to the outdoors. The exterior is currently being upgraded by the recently appointed maintenance person with safe paving, outdoor shaded seating, lawn and gardens. Interviews with staff confirmed there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. This audit also included verifying three existing rooms as suitable to be used again as resident's bedrooms. These three rooms were previous resident rooms being used for other purposes. All three rooms were adequate size for provision of resident care, had external windows, good heating/ventilation and call bells. All rooms were across the passage from a communal toilet and shower.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	All bedrooms are single occupancy with a hand basin and two bedrooms shared a full ensuite. There are communal toilets and showers located closely to the communal areas on both floors. Toilets have privacy locks. Residents interviewed confirmed their privacy was assured when staff were undertaking personal cares. Regular audits of the environment are completed as per the quality programme. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene and infection control practices for this environment.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	The residents' rooms meet the assessed resident needs. Residents are placed in rooms in which they can manoeuvre mobility aids. The bedrooms are personalised. All beds are of an appropriate height for the residents. Health care assistants interviewed reported that rooms have sufficient space to allow cares to take place and staff were seen to use hoists. Residents interviewed are happy with their rooms.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining	FA	There is a large combined lounge and dining room adjacent to the kitchen, along with additional smaller lounges and a kitchenette. The dining room is spacious and is easily accessible for the residents. The furnishings and seating are appropriate for the consumer group (a number of furnishings had been replaced in 2018). Residents were seen to be moving freely both with and without assistance throughout the audit. Residents interviewed reported they can move around the facility.

needs.		
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Aspen Lifecare has documented systems for monitoring the effectiveness and compliance with the service policies and procedures. There is a separate laundry area where all linen and personal clothing is laundered by the laundry staff. Staff attend infection control education and there is appropriate protective clothing such as aprons, gloves and masks available. There are dedicated laundry and cleaning staff. Manufacturer's data safety sheets are available. On a tour of the facility, the carpets were noted to be clean and free from stains. All bedrooms, hallways and communal areas were clean and tidy in appearance. Cleaning audits are conducted. Internal audits and resident satisfaction surveys identify any areas for improvement.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The service has an emergency/disaster procedures manual in place. There is a staff member with a current first aid certificate on duty 24/7. There is an approved NZ Fire Service evacuation scheme in place. Fire evacuation drills have been conducted six monthly with the last fire drill occurring on 3 May 2018. Civil defence, first aid and pandemic/outbreak supplies are available and are checked on a regular basis. Sufficient water is stored (water tank) for emergency use and alternative heating and cooking facilities (two BBQs and gas hobs in the kitchen) are available. There is a generator available to hire if there is a power failure. Emergency lighting is installed. There is an effective call bell system in place. Visitors and contractors sign in at reception when visiting. Security checks are conducted each night by staff.
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	All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Heating is provided by individual panels throughout the facility, including in each bedroom. Staff are easily able to adjust the temperatures to suit resident's needs. Residents and family interviewed stated the environment is warm and comfortable.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service	FA	Aspen Lifecare has an established infection control (IC) programme that is appropriate for the size, complexity and degree of risk associated with the service. The existing programme is in the process of being replaced and the Cavell group infection control programme (reviewed May 2018) and is being introduced. This is being undertaken in a considered way with all staff aware of any changes. A RN is the designated infection control coordinator and responsibilities for the role are described in the signed infection control coordinator position description. Infection control is discussed at the monthly RN/EN

providers, and visitors. This shall be appropriate to the size and scope of the service.		meeting. There was a norovirus outbreak in October 2017, which was notified.
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	There are adequate resources to implement the infection control programme at Aspen Lifecare. The infection control coordinator (RN) who has been in the role since January 2017 had no evidence on file that education for the role had been completed (link 1.8.2). External resources and support are available when required. Infection prevention and control is part of staff orientation and induction and is incorporated into the planned staff training day. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, and training and education of staff. The policies and procedures which reflect best practice, are accessed by the service through the local DHB.
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	PA Low	The infection control coordinator is responsible for coordinating/providing education and training to staff. The infection control coordinator has not completed specific infection control education since being in the role. The orientation package includes specific training around (but not limited to) hand hygiene and standard precautions. Infection control training is part of the mandatory one-day training programme which is held throughout the year to ensure all staff attend at least annually.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed	FA	The infection control programme describes and outlines the purpose and methodology for the surveillance of infections. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly infection summary. Short-term care plans are used. This data is monitored and evaluated monthly and annually. The

objectives, priorities, and methods that have been specified in the infection control programme.		infection control programme is linked with the quality management programme (link 1.2.3.6). Outcomes and actions are discussed at the RN/EN meetings. There has been one outbreak since the previous audit. There is close liaison with the nurse practitioners that advise and provide feedback/information to the service. Systems in place are appropriate to the size and complexity of the facility.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. Interviews with the staff confirmed their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. At the time of the audit, the service had two residents using restraints (both bed rails) as requested by the residents' families. There were no enablers in use. Staff training has been provided around restraint minimisation and management of challenging behaviours.
Standard 2.2.1: Restraint approval and processes 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.	FA	Staff receive training in the safe use of restraint (March 2017, 24 staff attended) and the management of challenging behaviour (April 2018). The acting clinical s manager has recently taken on the role of restraint coordinator in July 2018. A position description for the role has been signed.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Suitably qualified and skilled staff (including the GP), in partnership with the resident and their family/whānau, undertake assessments. Restraint assessments are based on information in the care plan, resident discussions and on observations of the staff. A restraint assessment tool had been completed for each of the two residents using a bedrail for safety. The care plans were up to date and provide the basis of factual information in assessing the risks of safety and the need for restraint. Ongoing consultation with the residents and families is also identified. Falls risk assessments are completed six monthly along with interRAI assessment.

Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service has an approval process that is applicable to the service. There are approved restraints documented in the policy. The approval process includes ensuring the environment is appropriate and safe. Assessments and care plans identify specific interventions or strategies to try (as appropriate) before restraint is used. The care plans of the two hospital residents being restrained were reviewed. Identified in one care plan was how to use the restraint safely along with the observations and monitoring to occur. In the second plan the monitoring was added at time of audit, however monitoring and recording was occurring. Restraint use is reviewed through ongoing assessment and six-monthly reassessment. A restraint register is in place.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation includes the areas identified in 2.2.4.1 (a) – (k). Evaluation occurs three monthly as part of the ongoing assessment for the resident on the restraint register, and as part of their care plan review. The family is included as part of the MDR review. Evaluation timeframes are determined by risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Individual approved restraint is reviewed at least three-monthly as part of restraint evaluations. Restraint usage throughout the organisation is also monitored regularly and reported monthly. The service has actively worked on minimising the use of restraint and on the day of audit the two restraints in use were at the request of family.

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)
Criterion 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	PA Low	The admission agreement meets with the requirement of the ARCC contract and Health and Disability Act.	Four of seven resident files (all rest home) did not have a current signed admission agreement on file.	Ensure all residents have signed admission agreements on file. 90 days
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where	PA Low	Quality data trends analysis related to incident and accidents, infection control, restraint and complaints are collected. However, there was no documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff. There is an annual internal audit calendar in place, however not all internal audits for 2017 and 2018 have been completed as per the required schedule. Advised the internal audit	i) There was no documented evidence that meeting minutes included discussion around quality data trends analysis and what actions were required by staff. ii) There is an annual internal audit calendar in place, however 41 of 51 internal audits for 2017 and 2018 year-to-date have not been completed as per the required schedule. Corrective actions required for the internal audits completed	i) Ensure that staff meeting minutes include discussion of quality data trends analysis and actions required, if any. ii) Ensure that all internal audits are completed as per the required schedule.

appropriate, consumers.		calendar is being reviewed and aligned to CAVELL audits.	that were not compliant, have not been fully completed or signed off.	90 days
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	There is an annual in-service training calendar schedule, however there was no documented evidence of mandatory two-yearly training being completed for cultural awareness/safety, abuse and neglect, code of rights, advocacy, open disclosure, complaints, spirituality, nutrition/hydration, pain management and care planning. An RN is the infection control coordinator.	Not all mandatory education/training has been completed within the required two-year period. Education not completed includes; cultural awareness/safety, abuse and neglect, code of rights, advocacy, open disclosure, complaints, spirituality, nutrition/hydration, pain management and care planning.	Ensure that the infection control coordinator undertakes specific infection control training Ensure that the annual education planner is implemented, and education is provided to cover all mandatory two-yearly training requirements. 90 days
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Moderate	Registered nurses completed initial assessments and care plans within 24 hours of admission for six of seven residents reviewed. Long-term care plans were completed within 21 days of admission for four of six long-term admissions (one did not require due to hospitalisation). Two residents do not require the interRAI assessment completed.	i) The respite rest home admission initial assessments and care plan had not been completed for the current admission. ii) One rest home admission did not have initial long-term care plan completed within 21 days.	Ensure that all aspects of assessments and care plans are completed within the required timeframes. 60 days
Criterion 1.3.5.2	PA	The RN is responsible for completing all	Interventions had not been fully	Ensure each

Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.	Moderate	necessary assessments and then using this information to document the care plan. In the files reviewed one resident had the long-term care plan documented before the assessments had been completed. The long-term care plan was not always updated following a change in care level and a care plan was not always documented for any acute changes in health condition. Wound assessment, monitoring and wound management plans are in place, however wound care documentation was not all fully completed. Nurses undertake a risk assessment for all residents however, interventions were not documented for all assessed care needs, and not all interventions in use had been documented in the care plan.	documented in the long-term care plan for; i) One rest home resident at risk of wandering and also using nicotine patches ii) One rest home resident with shortness of breath and recent significant weight loss iii) One rest home resident long-term care plan had not been amended following a change in mobility and had no interventions documented for management of diabetes. iv) One insulin dependent hospital resident did not include interventions to guide care staff in the management of diabetes including frequency of BSL monitoring and signs/risks of hypo and hyperglycaemia and/or actions to be taken.	residents care plan contains interventions to meet all assessed needs. 60 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 Moderate	The RNs are responsible for wound dressings including wound management plans and referrals to the GP or wound nurse specialist as required. The RNs are to complete neurological observations as per protocol for any unwitnessed falls or any known head injury.	A sample of 20 wounds were reviewed as part of this audit. (i) The following shortfalls were identified around wound documentation; a) seven of 20 wound management plans included multiple wounds on the same assessment and management plan; this was addressed during the audit; b) eight of 20 wounds plans with deterioration or malodorous discharge did not evidence input from the GP or wound specialists; c) four initial wound assessments did not fully describe the wound; d) twelve of 20 wound management plans did not follow the documented frequency of dressing changes; e) four of twenty wounds did not have a documented management plan.	(i)Ensure GP or specialist input is involved in wound care where wounds are deteriorating; Ensure all wounds have a documented assessment, management plan and that the dressing changes follow the documented plan. ii) Ensure that neurological observations are completed as per protocol for any unwitnessed falls or

			ii) Neurological observations had not been completed as per protocol for five of eight reviewed unwitnessed falls and any known head injury.	any known head injury. 60 days
Criterion 1.3.7.1 Activities are planned and provided/facilitated to develop and maintain strengths (skills, resources, and interests) that are meaningful to the consumer.	PA Low	The activity coordinator is responsible for documenting an initial profile including an activities assessment. The respite resident had regularly been admitted and there was no activity assessment or plan completed at any stage.	Two of seven residents (respite and long-term chronic health) do not have a documented assessment or an activities plan.	Ensure all residents have a documented assessment and plan. 90 days
Criterion 3.4.1 Infection control education is provided by a suitably qualified person who maintains their knowledge of current practice.	PA Low	The infection control coordinator is responsible for coordinating/providing education and training to staff. The infection control coordinator has not completed specific infection control education since being in the role	The infection control coordinator has not completed specific infection control education since being in the role	Ensure that the infection control coordinator undertakes specific infection control training 180 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.

No data to display

End of the report.