# New Windsor 2017 Limited - New Windsor Aged Care

## 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 HealthShare 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** New Windsor 2017 Limited

**Premises audited:** New Windsor Aged Care

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 18 February 2019 End date: 19 February 2019

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 18

# 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 |
|  | 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

A certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The service can care for up to 27 residents requiring rest home level care with an occupancy of 14 residents and four boarders on the day of audit.

The audit process included the review of policies, procedures and residents and staff files, observations and interviews with residents, family, management, staff and a medical officer. An interpreter provided support to the audit team to interview residents, family, managers and staff and to document the corrective actions in Cantonese/Mandarin.

The manager is responsible for the overall service and is supported by a registered nurse who provides clinical oversight. Service delivery is monitored.

Improvements are required to complaints management; open disclosure; management of incidents; staffing on the morning shift; the activities programme; medication management.

## 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 medium or high risk and/or unattained and of low risk. |

Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is brought to the attention of residents’ and their families on entry to the service and when requested with information interpreted into relevant languages spoken by residents and family. Residents and family members confirm their rights are met and that staff are respectful of their needs.

The manager is currently responsible for the management of complaints.

## 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 medium or high risk and/or unattained and of low risk. |

There are three directors in the company with the managing director providing support for the team on site. A manager provides operational oversight and leadership with a registered nurse providing clinical oversight.

There is a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed by an external consultant with quality and risk reported through meetings when these are held. There is a document control process in place.

There are human resource policies implemented around selection of staff; orientation; staff training and development. Residents and relatives have access to staff with a staff member on site at all times. A registered nurse is available on site at times during the week and the manager and registered nurse are on call at all times.

## 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 clinical nurse manager (CNM) is responsible for the development of care plans in consultation with staff and family members’ representatives where appropriate. Care plans and assessments are developed and evaluated. Short term care plans are developed for any acute needs as required.

An activities programme is in place.

The medication management system is documented. Medication is administered by staff with current medication competencies. The organisation uses an electronic system in prescribing, dispensing and administration of medications. Three monthly reviews are completed by the attending general practitioner (GP).

Residents are provided with nutritious meals that cater to their preferences and dietary requirements.

## 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. |

A current building warrant of fitness is in place and a New Zealand Fire Service evacuation scheme is approved. A preventative and reactive maintenance programme includes equipment and electrical checks. Fixtures, fittings and floor and wall surfaces are made of accepted materials for this environment.

Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed in a timely manner.

## 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. |

There are clear and comprehensively documented guidelines on the use of restraints, enablers and challenging behaviours. There were no residents using restraint or enablers at the time of the audit. Staff interviewed demonstrated a good understanding of restraint and enabler use and receive ongoing education around management of challenging behaviour.

## 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. |  | Standards applicable to this service fully attained. |

The infection control management systems are in place to minimise the risk of infection to residents, visitors and staff. The infection control coordinator (registered nurse) is responsible for co-ordinating education and training of staff. Infection data is collated monthly, analysed and reported during staff meetings. The infection control surveillance and associated activities are appropriate for the size and complexity of the service and is carried out as specified in the infection control programme.

## 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 | 39 | 0 | 2 | 4 | 0 | 0 |
| **Criteria** | 0 | 85 | 0 | 4 | 4 | 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **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 | All residents in the service are Chinese with English as a second language. The auditor identified that most residents could not speak English and an interpreter was used to interview eight residents including two boarders and one resident funded through a POAC contract, (primary options for acute care), and one family member. The interpreter used was independent to the organisation and could speak, read and write English, Cantonese and Mandarin. The interpreter also translated the corrective action plan left with the provider at the closing meeting to ensure that meaning was clear.  Residents and the family interviewed stated that they receive services that meet their cultural needs with information provided in Mandarin or Cantonese. Residents interviewed state that the information provided is relative to their needs and that staff respect their wishes.  Staff can explain rights for residents in a way that promotes choice. The posters identifying residents’ rights are displayed in the facility with these interpreted into Mandarin/Cantonese.  Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual education programme. All staff have had training in the last year. Interviews with staff including the cook, two activities coordinators, clinical nurse manager (CNM), cleaner/laundry assistant and two caregivers confirmed their understanding of the Code. Examples are provided on ways the Code is implemented in everyday practice, including maintaining residents' privacy; encouraging independence and ensuring residents can continue to practice their own personal Chinese values and beliefs.  The auditors noted respectful attitudes towards residents on the days of the audit. |
| 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. | FA | There is an informed consent policy. Consent is included in the admission agreement and sought for appropriate events and treatment. Staff were observed to use verbal consent as part of daily service provision. Staff interviewed demonstrated an understanding of informed consent processes.  Residents and relatives confirmed that consent issues are discussed with the relatives and residents on admission. Consent forms are shown to them on admission and thereafter as relevant. All residents' files reviewed include documented written consent.  The general practitioner is able to speak languages of the residents and is able to describe concepts such as advance directives to residents. Residents deemed competent by the general practitioner have the choice to make an advanced directive. In records reviewed, all competent residents have an advanced directive. The resident signs these. Some residents are identified as being ‘not for resuscitation and the general practitioner has noted  this as a clinical medical decision. |
| 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 Health and Disability Commissioner’s (HDC) Office is provided to residents and families as part of the admission process. Information is included in the welcome pack. Information on advocacy services is available at the entrance to the service. Information around advocacy services is translated into Mandarin/Cantonese.  Staff training on the role of advocacy services is included in training on the Code. Training is facilitated by the Health and Disability services advocate annually.  Resident files include information on resident’s family 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 | There are no set visiting hours and family report that they are encouraged to visit at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked.  Residents confirmed that they are supported and encouraged to access community services independently or with family with outings to appointments supported by the service. The service encourages the Chinese community to be a part of the residents’ lives with visits from entertainers. Special occasions are also celebrated at the service with a BBQ lunch celebrating the Lantern Festival well attended by family, residents, staff and others on the day of audit. |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | PA Moderate | The organisation’s complaints policy and procedures are in line with the Code and include periods for responding to a complaint. Complaint forms are available at the entrance of the facility. A complaints register was not able to be sighted on the day of audit (noting that this has been sighted at previous audits). The registered nurse, manager and managing director confirm that any complaints are taken seriously and responded in a timely manner. A review of four complaints received since the last audit confirmed that these are documented with an action plan in place. The forms are not reviewed by the manager and/or registered nurse.  Staff have completed training within the last year around management of complaints.  Residents and family member stated that when they have identified concerns in the past with the managing director, manager or registered nurse; they felt that they were listened to with issues resolved. All residents and family interviewed confirmed that they have been actively encouraged to express any concerns.  There has been not been any complaints from an external authority. |
| Standard 1.1.2: Consumer Rights During Service Delivery  Consumers are informed of their rights. | FA | The manager, managing director or the registered nurse discusses the Code, including the complaints process with residents and their family on admission. While the registered nurse does not speak mandarin or Cantonese, there is always a manager, staff member or family member with the registered nurse and resident who can interpret for them throughout the admission and review process.  The information pack includes information around rights in Mandarin/Cantonese and this can be produced in a bigger font, if required. Information is given to next of kin or an enduring power of attorney (EPOA) to read to and discussed with the resident in private. Residents and family members can describe their rights and advocacy services particularly in relation to the complaints process.  The managing director, registered nurse and manager were interviewed and can describe resident rights as per the Code. Information and processes have been put in place that ensure that resident rights are met. The manager has attended training in 2018 for managers and owners of services around resident rights and advocacy services. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect  Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act.  A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to manage any inappropriate behaviour if there are any issues for a resident.  The service ensures that each resident has the right to privacy and dignity. The residents’ personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room.  Caregivers report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. Practices consistent with this were observed on the days of the audit. Residents and family interviewed confirmed that residents’ privacy is respected.  Staff stated that they are committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive training annually on abuse and neglect and could describe signs. There were no incidents of abuse or neglect reported since the last audit. The general practitioner, residents, staff and family interviewed confirmed that there has been no evidence of abuse or neglect.  Staff interviewed were aware of the need to ensure residents are not exploited, neglected or abused and staff could describe the process for escalating any issues.  Resident files reviewed identified that cultural and /or spiritual values and individual preferences are identified through the assessment process. |
| 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 | The organisation has a policy that outlines the processes for working with people from other cultures. There is a Māori health policy that outlines how to work with Māori with reference to the Treaty of Waitangi.  Staff report that specific cultural needs for Māori would be identified in the initial cultural assessment. There are no residents who identify as Maori in the service. The managing director states that the service can access a needs assessor who identifies as Maori if required. This may be to support the service around tikanga protocols or general advice. The rights of the resident and family to practise their own beliefs are acknowledged in the policy.  Staff have had training around the Treaty of Waitangi and cultural sensitivity in 2018. The registered nurse states that the training always includes reference to supporting people who are Māori as part of the orientation and training programme. |
| 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 | The service serves a niche market of Chinese residents. All aspects of the service reflect Chinese life. New Windsor 2017 Limited - New Windsor Aged Care has continued to deliver a service that is culturally responsive to the needs of Chinese residents and their family. Staff identify as being able to speak Cantonese and/or Mandarin with English as a second language for most including those who are in roles as caregivers. Most staff can speak and understand English in a way that allows them to understand policies and procedures.  The managing director, registered nurse, cook and other staff showed an ability to cater for the Chinese population and to celebrate significant days in cultural calendars.  Spiritual and pastoral care is provided as appropriate to the cultural needs identified by each resident. Family are encouraged to be a part of the service with a significant number of family visiting this month to celebrate Chinese New Year. Chinese residents and family interviewed all stated that they enjoy the cultural component of the service.  The registered nurse identifies each resident’s personal needs at the time of admission through the assessment process. Staff or family support the resident with provision of information with support to interpret from the manager and/or managing director. Information gathered during assessment includes the resident’s cultural values and beliefs. |
| Standard 1.1.7: Discrimination  Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | Staff describe implementation of policies and processes around boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Training includes discussion of staff conduct and prevention of inappropriate care. Staff interviewed state that they are aware of the policies and are active in identifying any issues that relate to the policy.  Residents and family state that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination or exploitation.  Job descriptions include responsibilities of the position. The orientation and employee agreement provided to staff on induction includes standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregiver role and responsibilities. |
| Standard 1.1.8: Good Practice  Consumers receive services of an appropriate standard. | FA | There are policies and procedures to guide practice. These align with the Health and Disability Services Standards. Policies are reviewed as changes to legislation or practice occurs with these updated at regular intervals by an external consultant. The registered nurse has access to the internet and external expertise if they need to consult and/or gain further clinical knowledge or advice.  The education programme includes annual to two yearly training requirements for staff (or as changes to legislation are identified). Staff interviewed confirmed that the facility is a learning environment that meets their needs.  Residents and family member interviewed confirmed they are happy and satisfied with the care provided to their relatives and expressed a satisfaction with the care delivered. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | There are policies covering communication, access to interpreters and management interviewed reported that they have an open-door policy. Information is provided in a manner that the resident can understand as confirmed by residents and relatives interviewed.  The incident and accident forms include an area to document if the relatives have been contacted. Family are contacted in most of the incident forms reviewed.  There is a policy around use of interpreters and access to interpreting services is documented. Staff can describe how they would access interpreting services if required. Staff and family interpret for their family member as some residents speak Cantonese and others Mandarin. Staff in the service speak a mix of these languages. Residents and family confirmed that the languages staff speak enable to them to communicate well. Family confirmed that there is a lot of communication from the manager and registered nurse and they are encouraged to visit at any time.  Residents sign an admission agreement on entry to the service. Those reviewed were signed on the day of admission. The admission agreement provides clear information around what is paid for by the service and by the resident. The welcome book is translated into Mandarin/Cantonese and includes the philosophy, mission statement and values; privacy statement, information around the service provided; eligibility criteria; the complaints process, advocacy and interpreting services; activities and a description of key staff.  There is an opportunity to consider other ways of communicating with family overseas who do not speak or write in English e.g. when gaining input into the assessment and care planning process noting that the managers and staff do communicate with family who visit the service. |
| Standard 1.2.1: Governance  The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | The organisation is owned by three directors with the managing director having a role in operational management and leadership. The role of manager has been handed over to the relative of the managing director who has been off site for some periods of time since October 2018 (refer 1.2.4). The manager is on site for five to six days a week and provides operational oversight and maintains a maintenance role. The manager has always been actively involved in the service in the past and was always seen on site during audits.  The manager and managing director are supported by a registered nurse who provides 10 hours clinical oversight and input per week. The manager has completed over 16 hours of training in 2018 relevant to the role.  The philosophy is documented and reflects a focus on retaining as much independence as possible for each resident and on quality of care. The strategic direction for the organisation is newly documented with a business plan in place for 2018 to 2019. The purpose, values, scope, direction, and goals of the organisation are identified and reviewed.  An organisational risk management programme is documented with this reviewed in October 2018.  There are 27 rest home beds available and on the days of audit there were 14 residents in the facility all under the ARRC agreement and four boarders. There were no residents on any other contract and no residents under the age of 65 years. The auditors confirmed that the boarders do not require support and are independent. |
| 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 | The manager has taken over the role as leading operations and is supported by the registered nurse and the managing director who was previously in the role. There is always either the managing director or the manager providing day to day on site management of the site in the absence of the other. The managing director has been in overseas for a length of time since October 2018 and the manager has provided operational oversight with support for clinical aspects of care from the registered nurse. There is a signed contract for another registered nurse who can provide cover for the registered nurse if they are on leave. |
| 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. | FA | The service has implemented the quality and risk management framework and plan with the plan reviewed annually. Quality indicators are documented and are reviewed at least six monthly.  The service implements organisational policies and procedures to support service delivery. All policies are subject to review by the external consultant with all policies reviewed in 2017 and 2018. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines. Policies are available to staff in hard copy.  Service delivery is monitored through review and resolution of complaints; review of incidents and accidents; surveillance of infections; monitoring for any pressure injuries; feedback from residents and family and implementation of an internal audit programme. The corrective action plans are documented with evidence of resolution of issues.  The schedule of meetings includes a monthly staff meeting which includes all aspects of the quality and risk management programme and a resident meeting two monthly. Staff meetings are held as scheduled with attendance records indicating that there is good attendance by staff. The registered nurse is always present at the staff meetings. Staff report that they are kept informed of quality improvements through the managing director, manager and registered nurse.  The last satisfaction survey in 2018 for family and residents shows that they are satisfied with services provided and this was confirmed by residents and family interviewed.  The organisation has a risk management programme in place. Health and safety policies and procedures are documented and align with new legislation. There is a hazard management programme with any maintenance issues addressed as these arise. There is evidence of maintenance sheets completed when a hazard is identified. Health and safety is audited through the internal audit schedule. Review of incidents, risks, accidents and clinical issues are discussed through meetings and review of indicators at least six monthly. This includes review of pressure injuries; hospital admissions; falls; restraint; infections and medication errors. |
| 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. | PA Moderate | The managing director is aware of situations in which the service would need to report and notify statutory authorities however the change of manager has not been reported formally to the Ministry of Health.  Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand elements of the adverse event reporting process and can describe the importance of recording near misses.  Incident reports documented had a corresponding note in the progress notes in each relevant resident record. Information gathered around incidents and accidents is analysed with evidence of improvements put in place. |
| 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. | FA | The registered nurse holds a current annual practising certificate along with other health practitioners such as the general practitioner; dietician and pharmacist involved with the service.  Staff files include appointment documentation including signed contracts; job descriptions and reference checks if the staff member is unknown to the managing director or manager. There is an appraisal process in place with staff files indicating that staff have an annual appraisal.  All staff complete an orientation programme and caregivers are paired with a senior caregiver for shifts or until they demonstrate competency on a number of tasks including personal cares. Caregivers confirmed their role in supporting and buddying new staff.  The organisation has an annual training schedule documented with all staff attending each training offered. Training is provided at the service by the registered nurse with staff who speak English well interpreting for others if they have any queries. The content of each session is retained along with documentation of attendance and evaluation of each session. Education and training hours are at least eight hours a year for each staff member. The registered nurse has completed interRAI training with certificates sighted. The registered nurse has also completed at least eight hours training relevant to the role through work at another facility and through the District Health Board. |
| Standard 1.2.8: Service Provider Availability  Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | PA Moderate | All staff interviewed can speak English although all have English as a second language except for the registered nurse. Staff were interviewed with the interpreter present during the audit as required.  The staffing policy remains as the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels that meet resident acuity and bed occupancy with sufficient staff to cover shifts if others are on leave for the afternoon and night shifts.  Staff rosters confirm that there is always at least one caregiver on each shift. The staff complete cleaning and laundry and this is described by staff as manageable given the low acuity of residents and the low number of residents.  There are nine staff including the managing director, registered nurse, an activities coordinator and caregivers. The registered nurse works between four and 10 hours a week and is on call at all times for clinical issues. The managing director is also on call but defers any clinical issues to the registered nurse. Cooks prepare all meals. Residents and families interviewed confirmed staffing is adequate to meet the residents’ needs.  The change in name of the service has not impacted or changed the staffing policy or implementation of the policy. |
| Standard 1.2.9: Consumer Information Management Systems  Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The service retains relevant and appropriate information to identify residents and track records. This includes information gathered at admission, with the involvement of the family.  There are policies and procedures in place for privacy and confidentiality. Staff could describe the procedures for maintaining confidentiality of resident records. Files, relevant resident care, and support information can be accessed in a timely manner.  Entries are dated and signed by the relevant staff member. The designation of the staff member is documented. The name of the staff member entering the information is legible. The time of the entry is recorded only as the shift (morning, afternoon or night) and an improvement is required.  Resident records are protected from unauthorised access at all times. Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public.  Individual residents’ files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder in the medication room. Staff stated that they read the care plans at the beginning of each shift and are informed of any changes through the handover process. |
| 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 | New Windsor Rest home’s welcome pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies.  Records sampled confirmed that admission requirements were conducted within the required time frames and were signed on entry. The admission agreement clearly outlines services provided as part of the agreement to entry and is available in the language consumers can understand. The relative interviewed confirmed that they received sufficient information regarding the services to be provided. |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer  Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services. | FA | There is a documented process for the management of transfers and discharges. A standard transfer notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents’ records to confirm this. |
| Standard 1.3.12: Medicine Management  Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Moderate | The organisation uses the electronic system for e-prescribing, ordering, dispensing and administration. The e-prescribing electronic system is accessed by use of individual passwords and generic facility log in. Medication entries complied with legislation, protocols and guidelines. The facility uses pre-packed medication system by the pharmacy.  Pre-packed packs when delivered from the pharmacy are checked by the registered nurse with evidence of this sighted. An annual medication competency is completed for all staff administering medications and medication training records were sighted. Staff was observed during a medication round, they demonstrated knowledge and understanding of their roles and responsibilities of medication management.  There were no residents self-medicating at the time of the audit. The facility had systems and processes in place for self-administration should this be required.  There is an opportunity for improvement regarding conducting six monthly controlled drug (CD) stock takes and checking and returning expired as when needed medicines to the pharmacy. |
| 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 | Meal services are prepared on site and served in the allocated dining room. The menu has been reviewed by a registered dietitian to confirm it is appropriate to the nutritional needs of the residents. There is a four weekly rotating winter and summer meal in place. This is available for residents and family in Cantonese/Mandarin. The interpreter supported the auditor for interview of staff and review of documentation for the kitchen services.  The residents have a nutritional profile developed on admission which identifies dietary requirements, likes and dislikes and is communicated to the kitchen including any recent changes made. Diets are modified as required and the cook confirmed awareness on dietary needs required by the service. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required. The resident’s weights are monitored monthly and supplements are provided to residents with identified weight loss issues.  The kitchen and pantry were sighted and observed to be clean, tidy and stocked. Labels and dates are on all containers and records of food temperature monitoring, fridges and freezers temperatures are maintained. Regular cleaning is conducted. The food service was registered under new food control plan.  The residents and family interviewed acknowledged satisfaction with the food service. |
| 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 | The registered nurse reported that all consumers who are declined entry are recorded on the pre-enquiry form. When a resident is declined entry, relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred back to the referral agency to ensure that the resident will be admitted to the appropriate service provider. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Initial assessment tools are used to assess the residents’ needs, support requirements and preferences on admission. InterRAI assessments are completed in a timely manner. The assessed needs, outcomes and goals identified through the assessment process are documented to serve as a basis for service delivery. Assessments are conducted in a safe and appropriate setting as confirmed by the interviewed GP. Assessment outcomes are communicated to the residents and/or their family and referrers and relevant service providers. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | Care plans sampled were resident focussed, integrated and provide continuity of service delivery. Short term support needs and wound care plans are completed as when required. Residents, their family/whanau and relevant key workers are involved in the care planning process. The care plans sampled described the required support to achieve the desired outcomes identified by the ongoing assessment process. Service integration was sighted in the sampled residents’ files. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The documented interventions in short term support needs care plans and resident care plans are sufficient to address the residents’ assessed needs and desired goals/outcomes. Interventions are updated when required and interRAI triggered outcomes are addressed. Specialist advice is sought from other service providers and specialist services when required. Referral documents to other services and organisations involved in residents’ support were sighted in the sampled files. Interviewed family, residents and staff reported that they were satisfied with the services provided. Interviewed staff reported that there are adequate resources to meet safe resident care. Adequate medical/clinical resources were sighted and were appropriate to the size of the facility. |
| 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 | A monthly planner is posted on the notice boards that are accessible to residents. Residents and their family/whanau are consulted in the activity’s assessment and planning process. There is a wide range of activities offered by the service. There is community involvement with external entertainers invited, community groups, church and music groups. Evaluation of the individual activity plans are completed six-monthly.  Van outings are conducted once a week. Residents were observed participating in a variety of activities on the days of the audit. Interviewed residents and family members confirmed that the activities programme could be improved. An improvement is required to ensure activities are individualised and linked to interRAI assessments. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | Residents’ long-term care plans, interRAI assessments and activity plans are evaluated and updated when there are any changes. Family and staff are consulted in the review process. The evaluations record how the resident is progressing towards meeting their goals and responses to interventions. Short term support needs care plans are developed when needed and signed and closed out when the short-term problem has resolved. |
| 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 | Residents are referred to other health and disability service providers when required. Referral documents were sighted in the sampled files. The GP is involved in the referral process in consultation with the resident and/or their family where appropriate. Informed consent, general consent forms and referral documentation was sighted in records sampled. Residents and/or their family are given the choice and advised of their options to access other health and disability services where indicated. |
| 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 | Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.  Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances.  There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas. |
| Standard 1.4.2: Facility Specifications  Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | A current building warrant of fitness is posted in a visible location at the entrance to the facility. There have been no building modifications since the last audit.  A planned maintenance schedule is implemented. Any maintenance issues identified by staff are logged and attended to by the manager or contractors.  Indoor and outdoor space and seating arrangements provide for individual and group activities and all areas are suitable for residents with mobility aids. There are quiet areas for residents to sit. There are safe external areas for residents and family to meet/use and these include paths, seating and shade.  Equipment relevant to care needs is available and staff confirmed that there is always a sufficient amount of equipment. A test and tag programme is in place. Equipment is calibrated. |
| 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 | There are adequate numbers of accessible toilets/bathing facilities. Communal toilets are conveniently located close to communal areas. Communal toilet facilities have a system that indicates if it is engaged or vacant or a lock system.  Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.  Residents and family report that there are sufficient toilets and showers. |
| 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 | There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents interviewed all spoke positively about their rooms.  Rooms are personalized with furnishings, photos and other personal adornments and the service encourages residents to make the room their own. Rooms can accommodate couples with some having an opening between the rooms so that one room can be a bedroom that links directly to a lounge area.  There is room to store mobility aids such as walking frames in the bedroom safely during the day and night if required. |
| 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 needs. | FA | The service has a lounge and dining area with these spaces able to be used for activities. All areas are easily accessed by residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely. |
| 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 | Laundry is completed on site with covered laundry trolleys and bags in use for transport. The laundry area includes clean and dirty spaces. Dirty laundry was observed to be kept separate from clean laundry on the days of the audit. Residents and family stated that the laundry is well managed, and they do not have missing clothes.  Caregivers’ complete laundry and cleaning duties with those interviewed confirming that this is manageable given the numbers of resident currently in the service (refer 1.2.8).  There is a locked cupboard to put chemicals in and staff and the cleaner are aware that the trolley must be with them at all times. This was observed on the days of audit.  Chemicals are in appropriately labelled containers. Products are used with training around use of products provided throughout the year. Cleaning and laundry processes are monitored through the internal audit process with no issues identified in audits. |
| Standard 1.4.7: Essential, Emergency, And Security Systems  Consumers receive an appropriate and timely response during emergency and security situations. | FA | The New Zealand Fire Service has approved an evacuation plan. There have been no building reconfigurations since this date. An evacuation policy on emergency and security situations is in place. A fire drill takes place at least six-monthly with all staff having completed training. The orientation programme includes emergency and security training. Staff confirmed their awareness of emergency procedures.  There is always at least one staff member on duty with a first aid certificate.  All required fire equipment is checked within required timeframes by an external contractor. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and a gas BBQ. Emergency lighting is in place.  The doors are locked in the evenings. Systems are in place to ensure the facility is secure and safe for the residents and staff. External lighting is adequate for safety and security.  The call bell system is operational with bells in each room. Those tested on the days of audit were working and staff responded to call bells in a prompt manner. Residents interviewed confirmed that staff attend promptly when a bell is activated. |
| 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 | There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.  The service has an external area available for residents if they smoke.  Family and residents confirmed that rooms are maintained at an appropriate temperature. |
| 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 service provides an environment that minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme. The registered nurse is the infection control coordinator (ICC) and has access to external specialist advice from a general practitioner and the District Health Board infection control specialists when required. A documented job description for the ICC including role and responsibilities is in place with this signed by the registered nurse who is able to describe their role.  The infection control programme is reviewed annually, and a review of the education programme is conducted at this time. Staff are made aware of new infections through daily handovers on each shift and progress notes. The infection control programme is appropriate for the size and complexity of the service.  There are processes in place to isolate infectious residents when required. Hand sanitisers and gels are available for staff and visitors to use. There have been no outbreaks since the last audit as confirmed by the registered nurse interviewed. Staff interviewed demonstrated an understanding of the infection prevention and control programme. |
| 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 ICC is responsible for implementing the infection control programme and indicates there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at the staff meetings. The ICC has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively. The ICC has access to the general practitioner at any time and to the District Health Board infection control specialist. |
| 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 | Infection control policies are documented by an external provider and are current. Staff demonstrated knowledge on the requirements of standard precautions and can locate policies and procedures. |
| Standard 3.4: Education  The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | Staff education on infection prevention and control was facilitated by the ICC in May 2018 with all staff attending as confirmed through interview and as sighted in attendance logs.  The training education information pack is detailed and meets best practice and guidelines. External resources can be accessed for advice and information with staff able to describe how this occurs. Staff have also received training in 2018 as part of other training topics including waste management, wound management and skin care. Staff interviewed confirm an understanding of how to implement infection prevention and control activities into their everyday practice.  The ICC has completed training through an external provider around infection control in the last year. This was completed at another facility that the registered nurse works at. They have also completed Bug Control training in 2017. |
| 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. | FA | The ICC is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (e.g. facility-acquired infections) are documented to guide staff. Information is collated monthly. Surveillance is appropriate for the size and nature of the services provided.  Information gathered is clearly documented in the infection log maintained by the infection control coordinator. Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.  The infection control surveillance register includes monthly infection logs and antibiotic use. Infections are investigated, and appropriate plans of action are sighted in meeting minutes. The surveillance results are discussed in the staff meetings. Trends are analysed on an annual basis. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The service has a commitment to providing quality services for residents in a safe environment and work to minimise the use of restraint. All staff receive ongoing education regarding restraint minimisation and management of challenging behaviours. Staff interviewed were clear regarding the difference between a restraint and enabler use. The service currently has no residents using restraint or enablers. |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.1.13.1  The service has an easily accessed, responsive, and fair complaints process, which is documented and complies with Right 10 of the Code. | PA Moderate | Complaints are documented on relevant forms. There is documentation that confirms that verbal complaints are documented by staff on the forms. The assistant manager (administrator who was in the service for a month) was signing off the complaint’s forms. The manager has been signing off some of the complaints. Three of the four complaints related to care and should have had registered nurse oversight and sign off. | There is a lack of sign off of complaints and documentation of oversight of the complaint by the manager and/or registered nurse. | Ensure that the manager and/or registered nurse reviews each complaint and responds to the complaints appropriately as per policy.  90 days |
| Criterion 1.1.13.3  An up-to-date complaints register is maintained that includes all complaints, dates, and actions taken. | PA Low | The registered nurse confirms that there has been a complaint register in the past however a complaints register has not been documented since the last audit. There is a monthly compliments/complaints analysis completed with this up to date until January 2019. | A complaints register has not been maintained since the last audit. | Document a complaints register that includes all complaints, dates and actions taken.  180 days |
| Criterion 1.1.9.1  Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | Ten incident forms reviewed confirmed that in six, family had been contacted re the incident. | Four of the ten incident forms reviewed did not include documentation that confirmed that the family had been informed of the incident. | Ensure that family are informed of any incident and that this is documented.  180 days |
| Criterion 1.2.4.2  The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required. | PA Low | The managing director is aware of the reporting requirements to external authorities. The managing director and the manager stated that they have reported the change of manager to the District Health Board verbally however there is no formal documentation to confirm that the MoH and the District Health Board have been informed. | There is no formal documentation to confirm that the MoH and the District Health Board have been informed of the change in manager. | Notify the MoH and the District Health Board formally of the change in management.  30 days |
| Criterion 1.2.4.3  The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk. | PA Moderate | Ten incident forms reviewed confirms that incidents are being reported. Staff interviewed confirmed knowledge of the incident reporting process. Staff are not always completing neurological observations as per policy. Three of the ten incident forms were for residents who had banged their head or who had had an unwitnessed fall. None had neurological observations completed.  Incident forms did show sign off by the registered nurse with comments documented e.g. medication error – staff too busy. The comments and actions do not show that strategies have been considered to prevent the incident happening for the resident again or of a group of residents for whom the same incident may occur. | i) Neurological observations are not completed as per policy.  ii) Strategies to confirm that further action is taken to prevent the incident/s happening again are not well documented. | i) Ensure that neurological observations are completed as per policy.  ii) Document strategies to confirm that further action is taken to prevent the incident/s happening again.  90 days |
| Criterion 1.2.8.1  There is a clearly documented and implemented process which determines service provider levels and skill mixes in order to provide safe service delivery. | PA Moderate | There are sufficient staff on afternoon and night shift as evidenced through interviews with the manager, staff and a review of rosters for the last two months. The numbers of residents and boarders has increased since the last audit and the caregiver is struggling to meet the demands of residents on the morning shifts. The caregiver interviewed is diligent and explained how they review skin integrity at each shower in the morning. Staff also explained that Chinese culture influenced the level of care required on the morning shift with all residents wanting as shower in the morning for example. The staff member was observed on both mornings to complete tasks but was extremely busy during the shifts.  Two incidents for missed medication were reviewed. The registered nurse noted that staff were too busy and that is why medications were missed (refer 1.2.4).  Staff interviewed (including the registered nurse) stated that there is a lack of sufficient staff on duty in the morning and the activities coordinator is often pulled in to help the caregiver to provide cares. The manager is aware of the issue had has already interviewed for more caregivers. | There are not enough staff on the morning shift to support the needs of residents. | Continue to implement further staffing on the morning shift as planned and review staffing to ensure that tasks and numbers of staff meet the needs of residents.  60 days |
| Criterion 1.3.12.1  A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines. | PA Moderate | There was evidence that the GP undertake medication reviews every three months or earlier if indicated. Medication entries include any drug allergies and current photos uploaded. All medications are stored safely and securely. Weekly controlled drug (CD) stock takes were completed. There was no evidence of six-monthly checks being conducted. There were expired as when needed (PRN) medications in the drug trolley. | A process for checking and returning as when needed (PRN) medicines to the pharmacy is not implemented.  Six-monthly checks of controlled drugs are not completed | i) Implement a process for checking and returning as when needed (PRN) medicines to the pharmacy.  ii) Ensure that six-monthly checks of controlled drugs are completed  90 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 | Activities are planned by the activity’s coordinator and a resident profile support form is completed on admission. The activities provided take into consideration residents’ interests and ability however not all activities care plans were individualised and linked to interRAI assessments. | Not all activities care plans were individualised and linked to interRAI assessments. | Provide evidence that activities plans are individualised and linked to the interRAI assessments.  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.

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End of the report.