Golden Age Rest Home Limited - Camellia Court Rest Home, Golden Age Retirement Village, Albarosa Rest Home

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:	Golden Age Rest Home Limited
Premises audited:	Albarosa Rest Home||Camellia Court Rest Home||Golden Age Retirement Village
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 April 2019 End date: 1 May 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: 128

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

Golden Age Rest Home Ltd is part of the Golden Healthcare Group (GHG). The service is certified to provide rest home and dementia level care for up to 133 residents across three facilities – Golden Age Rest Home, Camellia Court dementia unit and Albarosa dementia unit. On the days of audit there were 128 residents.

This certification audit was conducted against the 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 family, management and staff.

Each facility manager is experienced in age care management and are supported by registered nurses and care staff. The facility managers are also supported by a corporate services manager, acting GHG clinical manager, a lead RN, quality assurance manager, operations manager responsible for human resource & compliance and an educator. Staff interviewed, and documentation reviewed identified that the service continues to provide services that are appropriate to meet the needs and interests of the resident group. Family interviewed all spoke positively about the care and support provided.

The audit identified that improvements are required around incident management and regular registered nurse resident reviews.

Consumer rights

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

Policies and procedures adhere with the requirements of the Code of Health and Disability Services Consumers' Rights (the Code). Residents and families are informed regarding the Code and staff receive ongoing training about the Code.

Personal privacy and values of residents are respected. There is an established Māori health plan in place. Individual care plans reference the cultural needs of residents. Discussions with residents and relatives confirmed that residents and where appropriate their families are involved in care decisions. Regular contact is maintained with families including if a resident is involved in an incident or has a change in their current health. Families and friends are able to visit residents at times that meet their needs. Examples of good practice were provided.

There is an established system for the management of complaints, which meets guidelines established by the Health and Disability Commissioner.

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.

Golden Age Rest Home Limited, including Golden Age Rest Home, Camellia Court dementia unit and Albarosa dementia unit, has an established quality and risk management system that supports the provision of clinical care and support. Quality data is collated for accident/incidents, infection control, internal audits, restraint use, pressure injuries, behaviours of concern, medications errors, complaints and surveys.

Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice. An orientation programme is in place for new staff. An education planner covers compulsory education requirements over a two-year period and includes competency assessments and external training opportunities. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care. Residents and families reported that staffing levels are adequate to meet the needs of the residents.

The integrated residents' files are appropriate to the service type.

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 low risk.

There is a comprehensive information package for residents/relatives on admission to the service. The registered nurses complete interRAI assessments, risk assessments, care plans and evaluations within the required timeframes. Care plans demonstrate service integration. Residents and relatives interviewed confirmed they were involved in the care plan process and review. Care plans were updated for changes in health status. The general practitioner completes an admission visit and reviews the residents at least three-monthly.

The activity team provide an activities programme in the rest home and separate programmes in the two dementia care units. The activity programmes meet the abilities and recreational needs of the groups of residents. There were individual 24-hour activity plans for dementia care residents.

There are policies and processes that describe medication management that align with accepted guidelines. Staff responsible for medication administration have completed annual competencies and education. The general practitioner reviews medications three-monthly.

A dietitian designs the menu. Individual and special dietary needs are accommodated. Nutritional snacks are available 24-hours for residents in the dementia care units. Residents interviewed responded favourably to the meals provided.

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.

There is a current building warrant of fitness. There are two dementia homes and a three-wing rest home area. There is a mix of rooms with full ensuite and shared ensuites. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. Each area has a lounge, dining area and safe access to the outdoor gardens with seating and shade.

There is a designated laundry for personal clothing. Other laundry is laundered off-site. Chemicals and cleaning trolleys are stored securely when not in use. The service has implemented policies and procedures for civil defence and other emergencies. Gas cooking, food, water and equipment is available in the event of an emergency. There is a first aider on duty at all times. Communal living areas and resident rooms are appropriately heated and ventilated. Residents have access to natural light in their rooms and there is adequate external light in communal areas.

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 is practiced and overseen by the north sector clinical coordinator for GHG. There are no residents using enablers or restraints.

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 surveillance programme is appropriate to the size and complexity of the service. The lead nurse is the designated infection control nurse with support from the registered nurses and managers. The infection control programme is linked into the incident reporting system and logged onto the benchmarking programme quarterly.

The infection control manual outlines a comprehensive range of policies, standards and guidelines. All infection control training is documented, and a record of attendance is maintained. Results of surveillance are acted upon and evaluated.

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	43	0	2	0	0	0
Criteria	0	91	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Golden Healthcare Group has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Families and residents are provided with information on admission, which includes information about the Code. Staff receive training about resident rights at orientation and as part of the annual in-service programme. Interviews with twelve care staff (four rest home and eight dementia), six registered nurses, two diversional therapists and one activities coordinator confirmed their understanding of the Code. The service actively encourages residents to have choices and this includes voluntary participation in daily activities. This was confirmed on interview with nine rest home residents and eleven relatives (seven dementia and four rest home). There are posters of the Code of Rights on display in the reception area of each facility and leaflets are available.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the	FA	The service has in place a policy for informed consent and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents including outings on all twelve resident files reviewed (five rest home and seven dementia), advance directives were completed by the resident where able, the general practitioner (GP) and discussion with family members is documented. Dementia residents have an activated enduring power of attorney in place (EPOA) in all seven files reviewed. A medical care guidance plan including admissions to hospital, end of life care and medically indicated resuscitation status is documented by the GP for dementia care residents, in consultation with the next of kin. Seven

information they need to make informed choices and give informed consent.		relatives/EPOA interviewed confirmed that all information was provided to enable informed choices and that they were actively involved in the resident's care and treatment. Resident admission agreements were signed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and advocacy pamphlet on admission. Interviews with family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives' meetings (minutes sighted). The service provides opportunities for the family/EPOA to be involved in decisions.
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. The activities programme includes opportunities to attend events outside of the facility. Residents are supported and encouraged to remain involved in the community.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy guides practice and aligns with Right 10 of the Code. The managers of each facility lead the investigation of concerns/complaints for their units. Complaints forms are visible and available for relatives. A complaints procedure is provided within the information pack at entry. The managers also document verbal complaints, and these are managed as per written complaints. Complaint registers are maintained for each individual unit. Seven complaints for 2018, and two complaints from 2019 year to date have been responded to and managed appropriately with letters of acknowledgement, investigations, staff meetings and memos and letters of response and outcomes to complainants. Two health and disability complaints from August and September 2018 are currently in progress. The service has complied with all requests and decisions are pending. The facility managers in each unit operate an "open door" policy.

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. Relatives and residents interviewed identified they are well-informed about the Code. Relatives and residents are informed of any liability for payment of items not included in the scope of the service. This is included in the service agreement. Resident meetings in each of the three units and surveys provide the opportunity to raise concerns.
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	There are policies in place to guide practise in respect of independence, privacy and respect. Staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. Residents are supported to attend other churches if they wish. Residents and relatives interviewed reported that residents are supported to make choices where able. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Staff have completed education around privacy and dignity.
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 service has a Māori heath plan and an individual's values and beliefs policy which includes cultural safety and awareness. Residents who identify as Māori have their cultural needs addressed in care plans. Linkages with Māori community groups are available and accessed as required.

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	Care planning and activities goal setting includes consideration of spiritual, psychological and social needs. Residents and family members interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs. Relatives reported that they feel they are consulted and kept informed and family involvement is encouraged. Residents are supported to attend church services of their choice if appropriate.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	Staff job descriptions include responsibilities. The monthly staff meetings include discussions around professional boundaries and concerns as they arise. Management provided guidelines and examples of mentoring for specific situations. Interviews with the managers and care staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Golden Health Group management are committed to delivering quality care with a strong emphasis on staff education and continued improvements in the delivery of resident focused care. Policies and procedures align with current accepted best practice. The content of policies and procedures are sufficiently detailed to allow effective implementation by staff. Care staff and RNs also have access/reference to aged care best practice guidelines. An annual in-service training programme is implemented as per the training plan with training for registered nurses from the DHB and involvement in the Careerforce programme for all caregivers. Residents' falls are analysed in detail. Feedback is provided to staff via the various meetings. Staff interviewed have a sound understanding of aged care and stated that they feel supported by the clinical staff, facility managers and support management team. Evidence-based practice is evident, promoting and encouraging good practice. Three house GPs visit the facility weekly. The service receives support from the local district health board (DHB). Physiotherapy services are available for nine hours per week. A podiatrist visits every six to eight weeks. The service has links with the local community and encourages residents to remain independent.

Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	There is policy to guide staff on the process around open disclosure and for residents who do not have any family to notify. The facility managers confirmed family are kept informed. Relatives stated they are notified promptly of any incidents/accidents as evidenced in the sample of incident reports reviewed. Families receive newsletters that keep them informed on facility matters and events. Resident/family meetings encourage open discussion around the services provided (meeting minutes sighted). There is access to an interpreter service as required.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Golden Age Rest Home Limited provides rest home and dementia level care for up to 133 residents. On the day of audit there were 128 residents - 51 in the rest home facility (Golden Age Rest Home) including one resident on a mental health contract, 37 in Camelia Court dementia facility (including one on an ACC contract) and 40 in the Albarosa dementia facility. All other residents were under the ARCC agreement. There is a facility manager in each facility, and all are experienced in aged care and management. The Golden Age Rest Home facility manager has been in the position for 15 years, the Camellia Court facility manager has been in the role for two and a half years and the Albarosa facility manager for nine years. The service is part of the Golden Healthcare Group (GHG), which operates eight facilities in Christchurch. The GHG organisation has an operations manager covering human resource & compliance, a quality assurance manager and a clinical manager. The clinical manager position is currently vacant and an experienced GHG relief manager is providing interim cover until an appointment is made. These positions work across all facilities and report to the corporate services manager. The corporate services manager reports to the owner/managing director of all the GHG facilities. The organisation employs three clinical lead positions, each of which provide clinical support to two or three GHG facilities. Golden Age Rest Home Limited has comprehensive quality and risk management systems implemented across its facilities. There is an overall GHG group strategic plan for 2016 - 2021 that includes development of new facilities, external audits, provision of a comprehensive range of services and occupancy. The GHG quality and risk management programme for 2019 includes a quality programme for Golden Age Rest Home Limited with clearly defined goals and objectives. Quality improvement projects are developed and implemented. Annual reviews are conducted of the quality and risk programme in January each year. Achievement of each goal is reviewed, and thresholds adjusted for the following year. Goals are set for the GHG group and for each individual facility. GHG benchmarks quality data against each of the eight facilities and reports across the group. The facility managers have all completed at least eight hours of professional development.

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 the temporary absence of a facility manager, the operations manager or relief manager provides cover with the support from the other facility managers, clinical manager, corporate services manager, human resource & compliance manager, quality assurance manager, clinical leads and registered nurses.
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	Golden Age Rest Home Limited has an established quality and risk management system which is embedded into practice. Quality and risk performance is reported across facility meetings and to the quality assurance manager. Discussions with the managers reflected staff involvement in quality and risk management processes. The service has policies and procedures, and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards, including those standards relating to the Health and Disability Services (Safety) Act 2001. Policies are reviewed two yearly in consultation with relevant expertise. Clinical guidelines are in place to assist care staff. Updates to policies including procedures, are introduced at staff meetings and circulated to all staff. The quality programme is reviewed at each quality and risk management facility meeting. The organisation also holds bi-monthly quality and risk management meetings where the organisational goals and plans are reviewed. Goals and objectives for 2018 have been completed and data collated against the other seven GHG homes. Golden Age Rest Home Limited has achieved most of the goals for the previous year. Where goals were not met, corrective actions are identified and implemented. Goals for 2019 have been documented and include key performance indicators. The GHG group have a documented mission statement, vision and values and a strategic plan for 2016 - 2021. The performance of the organisation continues to be monitored through the annual audit plan, policy and procedure review, family surveys, resident/family meetings, staff meetings, incident/accident review, complaints management, risk management surveying, the quality management programme, staff appraisals and orientation and the quality and risk management plan. Data is collated monthly and shared at staff and quality risk management meetings two monthly. Monthly comparisons, trends and graphs are displayed for staff information. The registered nurses and

		caregivers interviewed were aware of quality data results, trends and corrective actions. Falls prevention strategies are in place that include the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. An internal audit programme is in place and covers all aspects of the service. Data collected (eg, falls, medication errors, wounds, skin tears, pressure injuries, complaints and challenging behaviours) are collated and analysed for each resident involved. Quality data and results are documented in the quality and staff meetings and communicated to staff. Corrective actions are implemented where opportunities for improvements are identified. Areas of non-compliance include the initiation of a corrective action plan with sign-off by the quality assurance manager when implemented. Reviews and audits are conducted more frequently where issues are identified. There is an implemented health and safety and risk management system in place. Policies and procedures are in place to guide staff in managing clinical and non-clinical emergencies. The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Non-clinical accident/incident investigations are undertaken by the facility managers. There are hazard registers in each facility. Hazard registers are reviewed at the combined quality and risk meetings and annually in January. Staff confirmed they are kept informed on health and safety matters at staff meetings. Staff undergo annual health and safety training which begins during their orientation. Contractors are required to be inducted into the facility and sign a health and safety information sheet when this has been completed. Annual resident and relative surveys are conducted with excellent results achieved overall in each area. Golden Age and Albarosa for 2018 had almost 100% satisfaction with all aspects. Camelia Court identified opportunities for improvement and implemented a corrective plan to address these. Results have been collated and shared with residents, families and staff as evidenced in meeting minutes.
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	PA Low	There is an incident/accident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Staff have received training on completion of incident forms. Accidents/incidents were also recorded in the resident progress notes. The service reports aggregated figures to the staff/quality meeting and the quality and risk management meeting. Staff interviewed confirmed incident and accident data are discussed at the staff meeting and information and graphs are made available. Sixteen accident/incident forms for April 2019 were sampled across all three facilities. There has been RN notification and clinical assessment completed within a timely manner in the sample of reports reviewed. Neurological observations are carried out two-hourly for any suspected injury to the head. Accidents/incidents were also recorded in the resident progress notes. Forms included immediate follow-up by a registered nurse, however investigation and opportunities to minimise future events is not always documented. Discussions with the corporate services manager confirmed an awareness of the requirement to notify relevant

of choice in an open manner.		authorities in relation to essential notifications. Section 31 forms have been completed for an absconding event. Public health has been notified of two outbreaks.
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	There are organisational policies to guide recruitment practices and documented job descriptions for all positions. Appropriate recruitment documentation was seen in the ten staff files reviewed (one north clinical lead, three registered nurses, one cook, one activities coordinator, one housekeeper and three caregivers). Performance appraisals are current in all files reviewed. Interview with caregivers informed that management are supportive and responsive. All newly appointed staff complete general induction and role specific orientation. Health practitioners and competencies policy outlines the requirements for validating professional competencies. A register of practising certificates is maintained. There are currently five interRAI trained nurses. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed advised that new staff were adequately orientated to the service on employment. An education planner covers compulsory education requirements over a two-year period. Five RNs have completed interRAI training and further staff are booked to attend. Clinical staff complete competencies relevant to their role. There are 32 caregivers employed across the dementia facilities. Twenty-nine have completed the required dementia unit standards and three are in the process of completion. All three have been employed for less than 12 months. GHG have designed and implemented an emblem for the staff honours board to recognise staff who have completed their dementia training with a purple square with a white “D”. Management and staff reported staff turnover has been stable lately amongst caregivers. On interview, 12 care staff were positive regarding management support and all working conditions. Staff interviewed had worked for the organisation for between three and 43 years and stated there was minimal impact from staff turnover as there were always experienced staff available.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	Golden Health Group has a documented rationale for determining staffing levels and skill mixes for safe service delivery included in the rostering policy. The facility managers in each area provide an on-call service for any emergency issues or clinical support. There is always one staff member at least in each area on duty with a current first aid certificate. The rest home wing and two dementia units (Albarosa and Camellia), each have separate rosters. In the rest home wing with 51 residents, there is one RN on morning shift Monday to Friday and a second RN on two days a week. On morning shift there are five caregivers (all six and a half hour to eight-hour shifts) and an activities coordinator on five days a week. On afternoon shift there are three caregivers (two long and one short). On night shift there are two caregivers.

		In the Albarosa unit, there are 40 dementia residents (a 20-bed north and 20-bed south unit). The roster covers both units. There is an RN on Monday to Friday from 8.00 am to 4.30 pm who is supported by five caregivers (all full shift) and an activities assistant from 8.00 am to 4.30 pm Monday to Friday. On afternoon shift there are four caregivers (all full shift). On night shift there are two caregivers. In the Camellia unit, there are 37 dementia residents (a 19-bed north and 18-bed south unit). The roster covers both units. There is one RN on Monday to Friday with a second RN floating between Camellia and Albarosa four days a week including weekends. On morning shift there are four caregivers (all full shift). On afternoon shift there are three caregivers (all full shift) and on night shift there are twos caregivers. The service employs cleaners, laundry staff and kitchen staff including cooks and kitchenhands. The facility managers each work 40 hours per week. Care staff reported that staffing levels and the skill mix was appropriate and safe. Residents and family members interviewed advised that they felt there were sufficient staffing.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files are appropriate to the service type. All relevant initial information is recorded within required timeframes into the resident's individual record. All resident records containing personal information are kept confidential. Entries were legible, dated and signed with designation by the relevant caregiver or registered nurse. All files were integrated.
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	FA	Residents are assessed prior to entry to the service by the needs assessment team and permanent placement documentation is completed prior to admission. The admission welcome pack contains specific information for residents/relatives/EPOA which is provided on admission to the facility. This includes information such as the Health and Disability Code of Rights, advocacy and complaints procedure. There is information around the secure environment and potential behaviours of dementia care residents. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were included in the admission agreement. All twelve resident files reviewed had appropriately signed admission agreements.

services has been identified.		
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	The emergency policy outlines the procedures around transferring and what has to occur, depending on the reason for transfer. The manager is consulted prior to any resident transfer. The transfer/discharge/exit procedures included a transfer/discharge form and the completed form placed on file. All copies of documentation were forwarded with the resident and a copy on the resident file. The service uses the yellow envelope system for all transfers to hospital.
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.	FA	Medication policy and procedure comply with current legislation. The service has implemented an electronic medicine management system. All medications (blister packs) are checked by two RNs on arrival to the facility and discrepancies are fed back to the pharmacy. Medicine competent caregivers administer medications, the rounds sighted comply with medication guidelines. All staff administering medications have current competencies. Medications are stored safely in the rest home and the two dementia care homes. There are medicine fridges in each home. The temperatures of the medication fridges are recorded weekly and within the acceptable range. Eyedrops had been dated on opening. On the day of the audit there were 17 rest home level residents who self-administer creams and medicated powders. All residents have current self-medication competencies, which are reviewed three monthly. Medications are stored in a locked drawer in the resident's room. All 24 (10 rest home and 14 dementia) medication charts were clearly documented in the electronic system. All have photo identification; allergies and the last three-month review dates are documented. The signing sheets are correctly documented, and efficacy of 'as required' medications are documented. All 'as required' medications are prescribed correctly, and indication for use is documented. There was minimal use of 'as required' anti-psychotic medications used. Where required the effectiveness of 'as required' medications is recorded in the electronic medication system and progress notes.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's	FA	All meals are prepared and cooked on site in two kitchens. One large kitchen provides meals to rest home and retirement village residents. The other kitchen is located between the two dementia facilities and services both units. A five-weekly winter and summer company menu has been reviewed by a dietitian in March 2018 (Golden Age) and Albarosa & Camelia – May 2018. Resident dietary profiles and likes and dislikes are known to food services staff and RNs report any changes to the kitchen. The dietitian discussed resident food plans with the cooks when changes are recommended. Staff were observed assisting residents with their meals and drinks. Diets

individual food, fluids and nutritional needs are met where this service is a component of service delivery.		are modified as required. A vegetarian option is available on the menu. Supplements are provided to residents with identified weight loss issues. Weights are monitored monthly or more frequently if required and as directed by a dietitian. The service employs cooks who are supported by morning and afternoon kitchenhands. All staff have relevant food safety qualifications. Food is stored appropriately in both kitchens and pantries and is labelled and dated. The fridge, freezer and end cooked food temperatures were being recorded. The dishwasher temperatures and function are checked at least monthly by the chemical provider. A daily cleaning schedule is maintained. The food control plan expires 2 July 2019. Residents and family members interviewed indicated satisfaction with the food service. The kitchen staff stated that residents often give verbal feedback. Nutritious snacks are available 24 hours a day in all areas. There were nutritious snacks, finger foods and sandwiches readily available in the dementia home kitchen fridge.
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 service records the reasons for declining service entry to prospective residents should this occur and communicates this to prospective residents/family/whānau. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred to the referring agency if entry were declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely	FA	All twelve resident files had interRAI assessments completed by the needs' assessment team prior to admission. The registered nurses complete the first interRAI assessments within 21 days of admission. Risk assessments are completed on admission and at least six monthly and when there is a change in resident condition. Personal needs information is gathered during admission that formed the basis of resident goals and objectives. Behaviour assessments and management plans were included in the files reviewed of residents in the dementia units and in the rest home area where appropriate. The diversional therapists (DTs) complete an activities assessment. Assessments were noted to be completed on resident files reviewed and they are well linked to long-term care plans.

manner.		
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Resident files include all required documentation. The long-term care plan records the resident's problem/need and objectives. The outcomes of the interRAI assessments were linked to the care plans and interventions documented to achieve the resident goals. Long-term care plans reviewed across the rest home and dementia units identified that interventions documented supported current resident needs, and reflect input from MDT members such as physiotherapist, mental health team and dietitian. The resident file reviewed on the mental health contract has a current crisis plan, and interventions to support all current needs. Short-term care plans are in use for short term needs and acute changes in health status. Regular GP care is implemented, as sighted in current GP progress reports and confirmed at GP interviews. Resident files reviewed identified that family were involved in the care plan development and ongoing care needs of the resident. Relatives interviewed confirmed their involvement in the care planning process. Twenty-four-hour behaviour management plans were in place for the seven dementia care files reviewed. Behaviour management plans include potential behaviours, triggers and de-escalation techniques/strategies including diversional therapies.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the RN initiates a review and if required a GP visit. Communication to the GP for a residents' change in health status were sighted in the resident's files. Residents interviewed reported their needs were being met. Relatives interviewed stated their relative's needs were being appropriately met and they are informed of any changes to health as evidenced on the family consultation record held on each residents file. Rest home wounds include eight skin tears, one solar keratosis, and two superficial wounds. Wound assessments, plan and evaluations were in place for all wounds, and reflect wound progression or deterioration. The wound assessment form includes stages of pressure injuries and classification of skin tears. There were no pressure injuries on the days of audit. GPs are notified of all wounds, and progress is discussed at GP visits (sighted in GP notes). Adequate dressing supplies were sighted in the treatment rooms. Staff receive regular education on wound management. Registered nurses and senior caregivers maintain annual wound competencies. RNs describe access to the district nurses and Nurse Maude wound specialists if required for non-healing/complex wounds. Continence products are available and resident files include urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Specialist continence advice is available as needed and this could be described by the RNs interviewed. Monitoring charts/forms are in use to monitor progress including vital observations, neurological observations, weight, food and fluid, pain monitoring, blood sugar levels behaviour reporting chart, and 24-hour whereabouts charts for residents as required.

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.	FA	Rest home A diversional therapist (DT) is employed for 37.5hours a week and is supported by an activities coordinator for one day a week (six hours). Activity assessments are completed for residents on admission. The activity plan in the files reviewed had been evaluated at least six-monthly with the care plan review. The residents as appropriate, manager and DT are involved in the development of the monthly activity plan. A well-attended happy hour is held daily as well as a daily walking group, and scheduled exercises three days a week. There is newspaper reading and discussion each day, followed by a group activity. One-on-one activities are held later in the afternoon each day, which includes playing cards, going for a walk, or just having a chat. Van outings are available on Friday afternoons, where up to five residents go out for a drive and afternoon tea or a picnic. The DT has a current first aid certificate. Community activities include going to church services, attending the pancake race at a local church. There are some independent residents who are independent at going shopping. Entertainers visit regularly, the RSA attended the facility Anzac service recently. Special occasions are celebrated. Resident meetings are held three monthly and the minutes are displayed on noticeboards in the lounge. The residents interviewed commented on the variety of activities on offer, and particularly enjoy the happy hours, exercises and crafts. The relatives commented on the business of residents, and there is “always something going on”. Dementia homes – Camellia Court and Albarosa (North and South units) A DT is based in Albarosa Monday to Friday from 8.30 am to 4.30 pm. The DT implements a morning programme in the South unit and an afternoon programme in the North unit. Carers coordinate activities in the mornings/afternoons when the DT is in the other unit as observed during the days of audit. A carer is the activity coordinator in the weekends. There is an activity coordinator based in Camellia Court from Tuesday to Saturday 9.00 am to 5.30 pm. A carer/activity coordinator covers her days off. There are separate programmes for Camellia Court and Albarosa home. Activities are meaningful and include daily exercises to music, word games/quizzes, sing-a-longs, walks in the garden, gardening, baking, music, bowls, happy hours, newspaper reading, pampering (foot and hand massages) and reminiscing. One-on-one time is spent with residents. Residents are involved in household activities such as folding laundry and setting tables. There are knitting groups for the ladies and men’s activities which include sanding of furniture. Two residents are supervised to attend swimming at the public pools. A dance instructor visits monthly for “dance to be free” sessions. Doors between the North and South units can be opened up to allow all residents to attend big events in the large lounge. A trained massage therapist provides massage therapy (at relative request/consultation) for some residents as assessed. Events and special occasions are celebrated. Community visitors include entertainers, school children, pet therapy and church services. There are weekly van outings and drives to places of interest such as the beach, airport, gallery and picking daffodils. Feedback is received by residents, at the three-monthly family meetings and annual surveys. Families interviewed

		were very satisfied with the variety of activities offered.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Care plans reviewed had been evaluated by RNs six-monthly, or when changes to care occurred. Written evaluations describe the residents progress against the residents (as appropriate) identified goals. Previous outdated interventions are scored through and updated interventions are dated, and reflective of allied health recommendations. The crisis plan and long-term care plan has been evaluated/updated following a recent admission to hospital for the resident on the mental health contract. Care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. The multidisciplinary review involves a meeting with the resident and relatives. Relatives are notified of the outcome of the review if unable to attend. There is at least a three-monthly review by the medical practitioner. Relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and are fully informed of any changes to resident condition, incidents and accidents.
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 services (medical and non-medical) and where access occurred, referral documentation is maintained. Residents and/or their relatives/EPOA are involved as appropriate when referral to another service occurs. Family communication sheets confirmed family involvement. There is evidence that a resident's needs are re-assessed to ensure the level of care meets the resident needs. There has been a re-assessment for one dementia care resident to hospital level of care and there has been family involvement in the pending transfer to a hospital level of care facility.
Standard 1.4.1: Management Of Waste And Hazardous Substances	FA	There are policies and procedures in place for waste management and hazardous substances to ensure incidents are reported in a timely manner. Safety datasheets and products charts are readily accessible for staff. There are designated areas for storage of chemicals and chemicals are stored securely. There is a spills kit available. There are sluice rooms in each home with personal protective clothing available. There is a chemical mixing system in place. Chemical bottles sighted have correct manufacturer labels. Personal protective clothing is available for staff

Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		and was observed being worn by staff as they were carrying out their duties on the day of audit. Relevant staff have attended chemical safety training.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The service includes a two-storey rest home complex (54 beds) and two dementia facilities Camellia Court (north unit-19 beds and south unit -18 beds) and Albarosa (north unit 20 beds and south unit 20 beds). Each facility is connected by internal corridors. The building has a current warrant of fitness which expires on 1 July 2019. The property maintenance manager has been in the role for six weeks and covers all eight Golden Age Group (GHG) sites. He completes monthly audits of each site. At Golden Age there is a property assistant who completes and signs off any requests for repairs. There are hot water temperature checks conducted monthly in each home. Hot water has been maintained at 45 degrees to resident areas. Medical equipment has been checked and calibrated. Testing and tagging of electrical equipment has been conducted. Residents were observed safely mobilising throughout the facility. There is easy access to the outdoors. Courtyards are well maintained with safe paving, outdoor shaded seating, lawn and gardens. Each dementia home has double door entry with secure exits. The dementia care residents can freely access outdoor areas and gardens within their secure environment. Interviews with the registered nurses and the carers confirmed that there was adequate equipment to carry out the cares according to the residents' care plans.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy	FA	Resident rooms in the rest home have full ensuite facilities. Dementia homes have a mixture of ensuite rooms, shared ensuite facilities and communal toilets/showers. Fixtures, fittings, floor and wall surfaces are made of accepted materials to support good hygiene and infection prevention and control practices. The communal toilets and showers are well signed and identifiable and include vacant/engaged signs. Rest home residents interviewed confirmed staff respected their privacy when carrying out hygiene cares.

when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
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 are two double rooms in the Golden Age rest home. All other rooms are single through the facility. Resident rooms are spacious enough to meet the assessed needs of residents. Residents are able to manoeuvre mobility aids around their bed and personal space areas. Carers interviewed reported that rooms have sufficient space to allow cares to take place. Bedrooms are personalised as viewed on the day of audit.
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	There are large lounge and dining rooms and small seating areas in each home that are used for activities, recreation and dining activities. The dining rooms are spacious and located directly off the kitchen/servery areas. All areas are easily accessible for residents. Residents were seen to be moving freely both with and without assistance throughout the audit. The furnishings and seating are appropriate. New lounge chairs have been purchased for the dementia homes. The Albarosa dementia home is divided into two separate units. Each unit has a dining room and a lounge area. There is a quieter lounge “serenity and music” room. There is free access to the external gardens and grounds for each unit with raised garden beds, seating and shade. There is a locked door between each wing which is opened up for some activities (eg, entertainment). The Camelia Court dementia home is one unit and has three lounges and one large dining room plus another sitting room and two outdoor secure courtyard gardens. There are new lounge chairs throughout the facility. Artwork in the corridors assists residents with orientation to their rooms. There are plans to set up a cinema in one of the lounges.
Standard 1.4.6: Cleaning And Laundry Services	FA	There are documented systems for monitoring the effectiveness and compliance with the service’s policies and procedures. There is a separate laundry area where all personal clothing is laundered by the care staff. There is a smaller laundry located in between Camellia Court and Albarosa dementia homes. Cleaners complete flannels,

Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.		handtowels and separate kitchen washing. Larger laundry items such as towels and sheets, are processed off-site by a contracted company. The laundry areas have defined clean/dirty areas. Dirty laundry is picked up from an external collection point. Clean linen is delivered three times a week. There were adequate linen supplies noted in cupboards throughout the facility. Staff attend infection prevention and control education and there is appropriate protective clothing available. Cleaners are employed seven days a week. Manufacturer's data safety charts are readily available. Cleaners carry caddies with chemicals into the area they are cleaning. Cleaning trolleys are kept in locked areas when not in use. Internal audits and the chemical providers monthly audits monitor the cleaning and laundry service. Residents and family interviewed reported satisfaction with the laundry service and cleanliness of the facility.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The organisation has a documented emergency and disaster plan in place as per the Health and Safety programme. Six monthly trial fire evacuations are conducted. Fire and emergency training is included in staff orientation and regular ongoing sessions are undertaken throughout the year. Civil defence and emergency supplies are checked. The service ensures there is emergency food and water for a minimum of three days. There is sufficient stored emergency water in tanks and as bottled water to meet emergency requirements. There is a barbeque, gas bottles and access to a generator has been arranged. Emergencies, first aid and CPR are included in the mandatory in-services programme every two years and the annual training plan includes emergency training. Orientation includes emergency preparedness. There are staff employed across 24/7 with a current first aid certificate. Staff are required to ensure doors and windows are securely closed at night. There are documented security procedures. The fire alarms are linked between each building and staff carry a mobile phone to request assistance when required. There are call bells and emergency bells in all resident rooms and communal areas.
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	FA	All resident bedrooms have external windows with plenty of natural sunlight. The facility is heated, and windows open for ventilation. The general living areas and resident rooms were appropriately heated and ventilated on the days of audit. Family interviewed stated the environment is comfortable.

comfortable 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	Golden Age has an established infection control (IC) programme that is part of the GHG infection control programme. The infection control programme is appropriate for the size, complexity and degree of risk associated with the service and has been linked into the incident reporting system. The lead RN is the designated infection control nurse with support from the RNs, caregivers and the GHG quality and risk management team. The IC team at Golden Age is part of the quality and risk team meetings who review infection control matters. Minutes are available for staff. Regular audits have been conducted and education has been provided for staff. The infection control programme has been reviewed annually. There are outbreak kits in each facility which are located in the treatment rooms and checked monthly.
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 Golden Age. The infection control (IC) nurse is recently new in the role. The infection control team is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and wall mounted alcohol hand gel is freely available.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection	FA	The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies were developed by the GHG management team and have been reviewed and updated by the DHB nurse specialist. The policies are reviewed and updated at least two yearly.

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.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Golden Age is committed to the ongoing education of staff and residents. The Golden Age IC nurse with support from the RNs facilitates education. All infection control training has been documented and a record of attendance has been maintained. Visitors are advised of any outbreaks of infection and were advised not to attend until the outbreak had been resolved. Information was provided to residents and visitors that are appropriate to their needs and this was documented in medical records. Education around infection prevention and control has been provided in 2018 and 2019.
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	Infection surveillance is an integral part of the infection control programme. Monthly infection data is collected for all infections based on signs and symptoms of infections. All infections are entered into the infection/incident summary log in each resident file, and collated monthly. An individual resident infection form is completed which includes signs and symptoms of infection, treatment, follow-up, review and resolution. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. The infection control team (managers group) meet monthly to address issues and an infection control report is presented at staff meetings. There has been a recent outbreak in the dementia facilities. Albarosa had an outbreak of norovirus affecting 17 residents and one staff member. Camelia court had 23 residents affected and seven staff. All notifications were timely. There was daily reporting and updating all staff. An outbreak report was completed identifying what went well, and what improvements could be made. The outbreak was well managed.

Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	The service is committed to restraint minimisation and safe practice was evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by the north coordinator for GHG. There are currently no residents requiring restraint and no 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.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (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	All adverse events are documented on a paper-based form and evidence clinical review by registered nurse input, however not all events included full investigation and opportunities to minimise future events.	Ten of sixteen (five rest home and eleven dementia) incident forms reviewed did not include investigation and opportunities to minimise future events.	Ensure all incidents evidence opportunities to minimise future events. 90 days
Criterion 1.3.3.4 The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where	PA Low	Progress notes are maintained by caregivers at the end of each shift. Registered nurses document in the notes if there are concerns, changes in medications, following GP visits, and when an incident or infection has occurred, however there are no weekly reviews by a registered nurse documented consistently. There are separate GP notes, the dietitian documents in the GP notes, there	Four of five rest home files did not have weekly registered nurse entries (as per policy) with gaps	Ensure RN follow up is documented in a timely manner, and there are weekly RN

appropriate.		is separate physiotherapist and podiatrist notes.	ranging from 19 days to seven weeks.	entries in the progress notes as per policy. 60 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.