# Bupa Care Services NZ Limited - Gardenview 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](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:** Bupa Care Services NZ Limited

**Premises audited:** Gardenview Rest Home

**Services audited:** Dementia care

**Dates of audit:** Start date: 4 March 2020 End date: 5 March 2020

**Proposed changes to current services (if any):**

**Total beds occupied across all premises included in the audit on the first day of the audit:** 35

# 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

Bupa Gardenview is part of the Bupa aged care residential group. The service provides dementia level of care for up to 41 residents. On the day of the audit there were 35 residents.

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

The acting care home manager is a registered nurse and has aged care clinical and management experience with Bupa; having been the clinical manager at Gardenview prior to this role. She is supported by an acting clinical manager with aged care experience. The management team is supported by an experienced care home manager from a sister site and a regional operations manager.

The relatives spoke positively about the staff and the care provided at Bupa Gardenview.

This audit identified areas for improvement around; family communication post incidents, facility meetings, action plans and follow-up, registered nurse follow-up following incidents, dementia training, progress notes, care interventions and resident privacy.

## Consumer rights

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

Staff at Bupa Gardenview strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner’s Code of Consumers’ Rights. Policies are implemented to support residents’ rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

## 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. |

Bupa Gardenview has a documented quality and risk management system that supports the provision of clinical care. There is a documented schedule of quality activities such as internal audits and review of incidents and this has been fully implemented for 2020. Health and safety policies, systems and processes are implemented to manage risk. An education and training programme has been implemented with a current training plan in place. Appropriate employment processes are adhered to and all employees have an annual staff appraisal completed. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

## Continuum of service delivery

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| --- | --- | --- |
| 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. |

Registered nurses are responsible for the provision of care and documentation at every stage of service delivery. Information is gained through the initial support plans, specific assessments, discharge summaries, and the care plans to guide staff in the safe delivery of care to residents. The care plans are personalised, and goal orientated. Care plans are reviewed every six months or earlier if required, with input from the resident/family as appropriate. Files sampled identified integration of allied health and a team approach is evident in the overall resident file. There is a review by the general practitioner at least every three months.

The activities team implements the activity programme to meet the individual needs, preferences and abilities of the residents. The programme encourages the maintenance of community links. There are regular entertainers, outings, and celebrations.

Medications are managed appropriately in line with accepted guidelines. Registered nurses and senior caregivers who administer medications have an annual competency assessment and receive annual education. Medication charts are reviewed three monthly by the general practitioner.

Residents' food preferences and dietary requirements are identified at admission and accommodated. All meals and baking are cooked on site. This includes consideration of any particular dietary preferences or needs. There is a four-week rotational menu that is reviewed by a dietitian. Nutritional snacks are available 24 hours.

## Safe and appropriate environment

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| --- | --- | --- |
| 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. |  | Some standards applicable to this service partially attained and of low risk. |

The building has a current warrant of fitness. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Cleaning and maintenance staff are providing appropriate services. Cleaning and laundry services are monitored through the internal auditing system. Laundry is completed on site.

All rooms are single within the facility. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is sufficient space to allow the movement of residents around the facility using mobility aids. There is a spacious lounge and dining area in each wing within the facility, and a smaller family lounge available for quieter activities or visitors. Fixtures, fittings and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. The internal areas are ventilated and heated. The outdoor areas are safe, easily accessible and secure.

There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies. There is a staff member on duty on each shift who holds a current first aid certificate.

## Restraint minimisation and safe practice

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| --- | --- | --- |
| Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation. |  | Standards applicable to this service fully attained. |

Restraint minimisation and safe practice policies and procedures are in place. Staff receive training in restraint minimisation and challenging behaviour management. The service remains a restraint-free environment.

## Infection prevention and control

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| --- | --- | --- |
| 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 programme and its content and detail are appropriate for the size, complexity, and degree of risk associated with the service. The infection control coordinator is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Staff receive ongoing training in infection control.

## 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 | 37 | 0 | 6 | 2 | 0 | 0 |
| **Criteria** | 0 | 84 | 0 | 7 | 2 | 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 DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | The Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) poster is displayed in a visible location. Policy relating to the Code is implemented and staff can describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training (last provided April 2019). Interviews with staff (four caregivers, the acting clinical manager and agency registered nurse, the maintenance person, cook and two housekeepers) demonstrated their understanding of the key principles of the Code. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | The service has in place a policy for informed consent and resuscitation. General consent, consent for van outings, and flu vaccinations were sighted in all files reviewed. Completed resuscitation treatment plan forms were evident on all resident files reviewed. There was evidence of nurse practitioner (NP) completed and signed clinically not indicated resuscitation status. Discussions with relatives was evident in the family contact sheet and progress notes. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Signed admission agreements, enduring power of attorney and activation documentation was evident in the resident files sampled.  |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy services. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service encourages the residents to maintain relationships with their family, friends and community groups such as RSA and church groups by encouraging their attendance at functions and events and providing assistance to ensure that they are able to participate. Residents enjoy visits from local schoolchildren and mothers’ groups.  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | The complaints procedure is provided to relatives on entry to the service. The acting care home manager maintains a record of all compliments and complaints, both verbal and written, by using a complaint register (in hard copy and on the intranet). There have been five concerns/complaints for 2019 and none for 2020 year to date. Documentation including follow-up letters and resolution, demonstrated that complaints are being managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility.  |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available at reception. The acting care home manager and the acting clinical manager discuss the Code with residents and their family on admission. All six relatives interviewed, reported that the residents’ rights are being upheld by the service. Interviews with residents and family also confirmed their understanding of the Code. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | Residents are treated with dignity and respect. Privacy is ensured and independence is encouraged. Discussions with relatives were positive about the service. Residents' files and care plans identify residents preferred names. Values and beliefs information is gathered on admission with family involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training (February 2019). |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers 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 is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. They value and encourage active participation and input of the family/whānau in the day-to-day care of the resident. There were three residents that identified as Māori on the day of audit. One of three files for a resident who identified as Māori did not have this reflected into the care plan (link 1.3.5.2). Māori consultation is available through a local kaumātua. Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. All caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents.  |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service has established cultural policies aimed at helping meet the cultural needs of its residents. All relatives interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including resident’s cultural beliefs and values, is used to develop a care plan with resident (if appropriate) and/or their family/whānau consultation. Staff received training on cultural awareness in May 2019.  |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | A staff code of conduct is discussed during the new employee’s induction to the service and is signed by the new employee. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregivers’ role and responsibilities. Professional boundaries are reconfirmed through education and training sessions, staff meetings, and performance management if there is infringement with the person concerned. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | The acting care home manager, the acting clinical manager and a long-term agency registered nurse provide RN leadership Monday to Friday, additional support is also provided from a neighbouring Bupa home. The service receives support from the district health board, which includes visits from the mental health team and nurse specialists’ visits. Physiotherapy services are contracted and visit two weekly. There is a regular in-service education and training programme for staff. Policies and procedures meet current best practice and are readily available to staff.The service is implementing a series for initiatives to improve services. This has included a review of the quality system implementation including meeting management, education and collection and review of clinical quality outcomes (falls, pressure injuries, internal audits, as examples). Action plans have been recently documented to bring service systems up to date and to comply with Bupa processes. Additional improvements both ongoing and completed have included; improvements to resident information sticky labels, a new project to improve family communication, a successful project to improve the safety, practice and documentation around medication and an ongoing project to improve the resident meal experience.  |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | PA Low | Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. Evidence of communication with family/whānau is recorded on the family/whānau communication record, which is held in each resident’s file. Twelve accident/incident forms were reviewed from January 2019. Documented evidence of communication with family following an adverse event was not always evident. Relatives interviewed stated that they are kept informed when their family member’s health status changes.There are two monthly friends and family meetings that promote open communication. An interpreter policy and contact details of interpreters is available. Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The family/EPOA are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.  |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Gardenview rest home is a Bupa residential care facility. The service provides care for up to 41 residents who require a secure dementia level of care. On the day of the audit there were 35 residents. All residents are funded through the age-related contract. There are no respite residents. A vision, mission statement and objectives are in place. Annual goals for the facility were in the process of development. The service has annual goals that are reported quarterly. The goals for 2019 included: To reduce skin tears and bruising by 30%. A quality initiative has been implemented around this, as this was not achieved. Goal two, for all residents to have meaningful activities on offer over seven days. This will also roll over to 2020 as this goal was not achieved.The care home manager has been on extended leave. Bupa have put in place senior staff to ensure that clinical leadership continues for Gardenview. The acting care home manager has been in the role since January 2020 having been the clinical manager at Gardenview prior to that. The acting care home manager is supported by the care home manager from a neighbouring Bupa facility. The acting clinical manager who has been in the role since January and was a registered nurse at the service prior to this. Staff spoke positively about the support/direction and management of the current management team.The acting care home manager has maintained over eight hours annually of professional development activities related to managing an aged care service, including attendance at a Bupa forum over three days, that covered business management, health and safety requirements and investigations and hazard management.  |
| 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 organisation has acting care home managers who cover the facility care home manager for absences over two weeks. The experienced care home manager from a close Bupa service provides support and leave cover for short periods of leave. The operations manager, who visits regularly, supports both managers.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | PA Low | The Bupa quality and risk management programme is documented and supported through head office and the operations manager. Interviews with the acting managers and staff reflected their understanding of the quality and risk management systems.Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed at head office. New policies or changes to policy are communicated to staff. The monthly monitoring, collation and evaluation of quality and risk data includes (but is not limited to) resident falls, infection rates, complaints received, pressure injuries and wounds. Quality data is entered into the organisational RiskMan data base where results are benchmarked against quality indicators. A corrective action plan is required for any results above the quality indicator. An annual internal audit schedule including environmental, support services and clinical audits was sighted for the service. A review of the quality system implementation evidenced that it was not fully implemented for 2019. This included fully entering all statistics into RiskMan, ensuring meetings have been documented as taking place, follow-up of internal audits and quality plans. The acting care home manager, support care home manager from another Bupa service and the regional manager have commenced a process to ensure that Bupa systems are fully implemented, this process is ongoing.For 2019 and 2020 year to date, audits had been completed as per schedule. Where the result was less than expected, corrective action plans had not always been documented. Action plan for internal audits, the resident/family survey and action plans following family focus groups had not been documented as followed up or signed off. There is a system of meetings scheduled including; two monthly staff meetings, quarterly quality meetings, monthly RN meetings and newly initiated falls meetings. Quality and risk data, including trends and benchmarked results were not consistently discussed in staff meetings and meetings did not consistently take place for 2019. Meetings scheduled for 2020 have taken place as per schedule.The health and safety committee are representatives from each service area and meetings have taken place. All policies and procedures meet the health and safety requirements. There are national health and safety goals. Staff interviewed stated they have the opportunity to provide input at the health and safety committee meetings. Hazard management is discussed and there is a current hazard register in place. Falls prevention strategies are managed on an individual basis and minimised.  |
| 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 | There is an accident and incident reporting policy. Adverse events are reviewed and signed off by the acting care home manager or acting clinical manager and this was evidenced in all eleven accident/incident forms reviewed using the RiskMan electronic database. Not all incidents reviewed documented a follow-up by a registered nurse in either the progress notes or RiskMan to ensure the ongoing safety/comfort of the residents and to minimise further incidents occurring. Not all incidents had an incident form documented.Discussions with the acting care home manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. Appropriate notification was made around an outbreak in January 2020.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Eight staff files reviewed (one acting clinical manager, two registered nurses, one activities person, one cook, one maintenance/health and safety and two caregivers) evidenced implementation of the recruitment process, employment contracts, completed orientation, and annual performance appraisals. A register of practising certificates including all health professionals involved in the service is maintained.The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The orientation programme is developed specifically to worker type (eg, RN, support staff) and includes documented competencies. The caregivers when newly employed, complete an orientation booklet that has been aligned with foundation skills unit standards. On completion of this orientation, they have effectively attained their level two-unit standards. The service is working with Careerforce and staff to assist access to Careerforce.Sixteen caregivers work across the dementia units. All staff, except five caregivers, have completed dementia unit modules. One caregiver is new and four have been employed for over two years.There is an annual education and training schedule being implemented. Opportunistic education is provided via toolbox talks. Many education sessions have been repeated to ensure that staff have as many opportunities as possible to attend, this has resulted in a good attendance rate. Education and training for clinical staff is linked to external education provided by the district health board. Specific competencies are included according to the role such as medications, wound management, cardiopulmonary resuscitation and syringe driver for RNs. The acting care home manager and acting clinical manager are both interRAI trained. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | The staffing levels meet contractual requirements. The acting care home manager and the acting clinical manager are on duty Monday to Friday and on call after hours. The service has employed a long-term agency RN whist they recruit for a long-term RN (commencing April 2020). Interviews with the residents and relatives confirmed staffing overall was satisfactory and increased to manage resident acuity and occupancy. The service is divided into two wings. During the day the doors are open between the wings and only closed during mealtimes and at night.Rimu wing had 20 residents and Pakeke wing had 15 residents. Each wing has the following caregiver staffing;AM: two full shifts, PM: one 3 pm to 11 pm and one 4 pm to 10 pm, plus a supper assist staff member 4 pm to 7 pm. There are two caregivers overnight.There are two activity staff who work over seven days a week, one of whom works until 6 pm.There are designated food services staff, cleaning and laundry staff.  |
| 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. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident’s individual record. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents’ files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.Residents’ files demonstrated service integration. Entries are legible, timed, dated and signed by the relevant caregiver or nurse, including designation. |
| 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 | The service has comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. The service has a well-developed information pack available for residents/families/whānau at entry. The admission agreement reviewed ARC contract and exclusions from the service are included in the admission agreement. The six admission agreements viewed were signed by the activated enduring power of attorney (EPOA). Information gathered at admission is retained in resident’s records. Relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the manager. An advocate is available and offered to family.  |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives are notified if transfers occur as sighted in one resident file where a resident was transferred to hospital. Discussions with the acting clinical manager evidences a good understanding of the transfer process.  |
| 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 | There are comprehensive policies and procedures in place for all aspects of medication management. The facility utilises an electronic medication management system. Twelve medication profiles were sampled. All charts had photo identification and allergy status documented. All medication sheets evidenced three monthly reviews by the NP. Prescribed medication is signed electronically after being administered as witnessed on the day of the audit. Effectiveness of PRN medication administered were documented in the electronic prescription. Controlled drugs and registers align with guidelines. There were no residents self-administering and this is appropriate for this setting. There are two medication rooms on site, both have secured keypad access. Medication fridges and medication room temperatures had daily temperature checks recorded and were within acceptable ranges. All medications were securely and appropriately stored. Registered nurses or senior caregivers who have passed their competency, administer medications. Medication competencies are updated annually. There is a signed agreement with the pharmacy, which is held at head office. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no standing orders.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | All meals at Gardenview are prepared and cooked on-site. There is a Bupa wide four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. All food preferences are met. Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food being served to the residents are recorded. A current food control plan is in place expiring 22 September 2020. Kitchen staff have completed food safety education. Staff were observed assisting residents with their meals and drinks. Supplements are provided to residents with identified weight loss issues. Resident and relative meetings and surveys allow for the opportunity for relatives to feedback on the meals and food services generally. Relatives interviewed were satisfied with the meals and confirmed alternative food choices were offered for dislikes. A current initiative the service has been focusing on has been around residents who are losing weight unintentionally. These residents are active and enjoy walking around and were identified to be often refusing meals. Residents with identified unintentional weight loss are encouraged to sit at the table with people, to encourage the social interactions and tempt the resident to sit at the table for longer, ramekins have been purchased so the meals are smaller. A form has been developed for staff to complete to record the food intake of residents with weight loss. The dietitian has been involved and the service is working with a company to source food moulds to make the textured diets more attractive and appetising. On the day of the audit there were two residents with unintentional weight loss, the kitchen staff describe providing fortified milkshakes, supplements, and nutritious tasty treats were available 24 hours a day for all residents.  |
| 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 reason for declining service entry to potential residents should this occur and communicates this to potential 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 back to the referring agency for appropriate placement and advice.  |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | Bupa assessment booklets and LTCPs reviewed were comprehensively completed and either archived or present in resident files reviewed. The assessment booklet provides in-depth assessment across all domains of care. InterRAI assessments and risk assessments were implemented and reflected into the care plans (link 1.3.5.2). Risk assessments are completed on admission and reviewed six monthly as part of the interRAI assessment, or when there is a change in residents’ condition. Additional assessments for management of behaviour were appropriately completed as required.  |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | PA Low | Care plans reviewed were comprehensive and demonstrated service integration and input from allied health. The interRAI assessment process informs the development of the residents’ care plan. Communication and meetings with relatives were evidenced in the documentation reviewed. Overall, resident care plans were resident-centred and documented in detail their support needs. However, long-term care plans did not always detail care and support for behaviours that challenge, including triggers, associated risks and management. Staff interviewed reported they found the care plans easy to follow. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved. There was evidence of service integration with documented input from a range of specialist care professionals. Relatives interviewed all stated care delivery and support by staff was of a high standard.  |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | PA Moderate | Registered nurses (RNs) and caregivers follow the care plan and report progress at each shift handover. The care plans reviewed did not always include all documentation that meets the need of the residents or updated as residents’ needs changed (link 1.3.5.2). If external allied health requests or referrals are required, RNs initiate the referral (eg, wound care specialist, dietitian, or mental health team). The NP interviewed on day of audit spoke highly of the service and confirmed of being kept informed of changes in resident condition. Relatives agreed that the clinical care is good and that they are involved in the care planning. There were seven wounds on the day of the audit, (six skin tears and one scratch). There were also two current pressure injuries (one unstageable and one stage 2).Wound assessment, wound management and evaluation forms are in place for all wounds, however, not always fully completed. The pressure injuries had not been staged correctly, and no notification had been made for the unstageable pressure injury (a RiskMan assessment was sent to head office on the day of the audit, however, described as a stage 3) (link 1.2.4.2). An incident report had been documented for the stage 2 pressure injury. The NP was aware of the wounds, and specialist advice had been sought from general surgery and a specialist podiatrist for pressure relieving strategies and a special boot for the unstageable pressure injury. Access to specialist advice and support is available as needed. Care plans document allied health input. There is specialist continence advice as required. Continence assessments have been completed at least six monthly, and adequate supplies were sighted. An education session has been held around continence and the caregivers interviewed were knowledgeable around the use and types of products available.Interviews with registered nurses and caregivers demonstrated understanding of the individualised needs of residents. There was evidence of monthly weight and vital sign monitoring, food and fluid charts, behaviour monitoring, and blood sugar level monitoring.  |
| Standard 1.3.7: Planned ActivitiesWhere 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 | The service employs two activities coordinators who cover activities across seven days a week and hold current first aid certificates. The activities coordinator interviewed has recently been appointed and has completed orientation at a sister facility and at Gardenview. The activities team ensure all residents have a ‘map of life’ competed on admission. They develop the activities and socialisation section of the care plan and ensure reviews are completed at least six monthly. Attendance records were maintained in the resident files reviewed. Activities coordinators have set days with one working Tuesday to Saturday from 10 am to 6 pm. The other activities coordinator works from 9 am – 3 pm Sunday to Thursday.The monthly planner is developed to include a range of activities to include church services, puzzles, bingo, mini golf, daily exercises, and group games. The activities coordinator interviewed described de-escalation of residents by gently diverting them off for a one-on-one walk. There is an aviary in the garden and plans for more animals to join Gardenview. One-on-one activities include talking to the residents individually, hand massages, passive exercises, going for walks around the gardens, and reminiscing with photos in resident rooms. Van outings are available weekly and include a monthly lunch and a weekly trip to the senior citizens dance club. Regular entertainers visit the facility.The relative meeting provides suggestions and feedback to the programme.  |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | The files reviewed demonstrated that all interRAI assessments and care plans reviewed were evaluated at least six monthly or when changes occur (link 1.3.5.2). Short-term care plans for short-term needs were evaluated and either resolved or added to the long-term care plan as an ongoing problem. All changes in health status are documented and followed up. The multidisciplinary review involves the RN, GP, activities staff, family and acting clinical manager. The files reviewed reflected evidence of family being involved in the planning of care and reviews. The care plans reviewed had been read and signed by EPOA/family. There is at least a three-monthly review by the nurse practitioner with majority of residents being seen monthly. The relatives interviewed confirmed they are invited to attend the multidisciplinary care plan reviews and GP visits.  |
| 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 | Referral to other health and disability services is evident in the sample group of resident files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The acting clinical manager initiates referrals and specialist referrals are made through the GP. There was evidence of where a resident’s condition had changed, and the resident was reassessed for a higher or different level of care. Discussion with the acting clinical manager identified that the service has access to a wide range of support either through the GP, Bupa specialists and contracted allied services.  |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are implemented policies in place to guide staff in waste management. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly in the original containers, and safety data sheets and product information is readily available to staff. Gloves, aprons and goggles are available, and staff were observed wearing personal protective clothing while carrying out their duties. Staff have completed chemical safety.  |
| 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 building has a building warrant of fitness that expired 28 February 2020 (awaiting on new certificate). There is a maintenance/gardener staff member who works 40 hours per week across two Bupa sites and is available on call for facility matters. Planned and reactive maintenance schedules are in place and maintained. All electrical equipment has been tested and tagged (due October 2020). Hot water temperatures have been tested and recorded fortnightly with corrective actions for temperatures outside of the acceptable range. There is safe access to all communal areas for residents requiring mobility aids. There are two open plan lounge/ dining areas and one smaller quiet family/ whanau lounge, small quiet low stimulus areas are placed around the facility. The two main lounge/ dining areas have access to secure external areas with an aviary for residents to enjoy. Seating and shade are provided. Corridors are wide in all areas to allow residents to pass each other safely. Staff stated they have all the equipment required to provide the level of care documented in the care plans. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers 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. | PA Low | The facility has two wings (Rimu wing has 20 rooms and Pakeke wing has 21 beds). There are five toilets and three showers in Rimu wing and there are four toilets and three showers in Pakeke wing. There are adequate visitor and staff toilet facilities available. Communal toilets and bathrooms have appropriate signage and shower curtains installed, however, there was no privacy locks or privacy curtains in the toilets. The caregivers interviewed reported resident’s privacy is maintained at all times.  |
| 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 | All resident’s rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. There are no double rooms. Residents are encouraged to personalise their bedrooms as sighted during the audit.  |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are large lounges and large adjacent dining rooms in each wing. All lounge/dining rooms are accessible and accommodate the equipment required for the residents. Activities occur throughout the facility. Residents are able to move freely and furniture is well arranged to facilitate this. Residents were seen to be moving freely both with and without assistance throughout the audit. There is adequate space to allow maximum freedom of movement while promoting safety for those that wander. A smaller whānau lounge is situated in the Pakeke wing for residents and relatives to enjoy.  |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | There are designated housekeeping staff who completes the cleaning and laundry service. The lockable cleaning trolley is well equipped, and all chemicals are labelled, the trolley is locked and stored in a locked room when not in use. Protective wear including plastic aprons, gloves, masks and goggles are available in the laundry. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties.The laundry has a clean/dirty flow. Internal audits monitor the effectiveness of the laundry service. Residents expressed satisfaction with cleaning and laundry services.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | A fire evacuation plan is in place that has been approved by the New Zealand Fire Service on 26 June 2014. There are emergency management plans in place to ensure health, civil defence and other emergencies are included. Six monthly fire evacuation attendance documentation was sighted. Fire training and security situations are part of orientation of new staff and are ongoing as part of the annual training plan. There are adequate supplies in the event of a civil defence emergency including food, water, backup battery power and gas barbeque. There is an arrangement with a local hire centre to provide a generator on request. Emergency lighting is in place. A minimum of one person trained in first aid and cardiopulmonary resuscitation (CPR) is available at all times. There are call bells in the residents’ rooms, toilets and showers and lounge/dining room areas. Residents were observed to have their call bells in close proximity. The facility is secure after hours with security lighting and security patrols at night.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows on security stays which open and allow plenty of ventilation and natural sunlight into the rooms. There are heat pumps situated around the building, resident rooms have automatic heating. General living areas and resident rooms are appropriately heated and ventilated. Relatives interviewed stated the environment was warm and comfortable.  |
| Standard 3.1: Infection control managementThere is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.  | FA | The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well informed about infection control practises and reporting. The infection control coordinator (acting clinical manager) is responsible for infection control across the facility. The infection control committee and the Bupa governing body is responsible for the development and review of the infection control programme. The infection control programme is well established.Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are given the influenza vaccine with consent from their EPOA.  |
| Standard 3.2: Implementing the infection control programmeThere 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. The infection control (IC) coordinator has not attended infection control training, however the Bupa infection control specialist maintains oversight. The infection control committee meet two monthly. External resources and support are available through the Bupa quality and risk team, external specialists, microbiologist and DHB when required. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | The infection control manual outlines a comprehensive range of policies, standards and guidelines and defines roles, responsibilities and oversight, the infection control team, training and education of staff and scope of the programme. |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control coordinator is responsible for coordinating/providing education and training to staff. The orientation package includes specific training around hand hygiene and standard precautions. Annual infection control training is included in the mandatory in-services that are held for all staff. The infection control coordinator has access to the Bupa intranet with resources, guidelines best practice, education packages and group benchmarking. .  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.Effective monitoring is the responsibility of the infection control coordinator. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections. Surveillance data is available to all staff. Infections are entered into the electronic data base for benchmarking. Corrective actions are established where trends are identified. There has been one confirmed norovirus outbreak in April 2019. Public health were notified with ongoing correspondence during the outbreak period. Case logs and outbreak documentation was sighted. The service received a complimentary letter from the public health department regarding their handling of the outbreak.  |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | FA | The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The acting clinical manager is the restraint coordinator. The restraint standards are being implemented and implementation is reviewed through internal audits, facility meetings, and through quarterly teleconference with Bupa restraint coordinators. Staff receive education on restraint, dementia and challenging behaviours. The service remains restraint-free, there were no residents using enablers or restraint.  |

# 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 1.1.9.1Consumers have a right to full and frank information and open disclosure from service providers. | PA Low | The service enters all incident and accidents onto RiskMan, this includes the incident, follow-up and family communication. Seven falls and one skin tear all recorded that family had been informed. One of three medication errors documented that family had been informed. | Two of three medication administration errors did not document if family had been informed of the incident. | Ensure that family are informed following all adverse events relating to their family member at the service.90 days |
| Criterion 1.2.3.6Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers. | PA Low | Bupa has clearly documented processes around collecting, reviewing, presenting and discussing quality information with staff in order to improve services. This process has not been fully implemented for 2019. | (i). Meetings have not always been held as per schedule for 2019, examples include staff meeting August, October and November, there were no quality meetings documented after May 2019 (until 2020). There were no family meetings, since June 2019 (until 2020).(ii). Meetings held for 2019 did not all document that quality information was presented to meetings. Examples include incident and accidents, infection control, internal audit results and complaints. | (i). Ensure the new process of holding meetings as per the Bupa schedule is fully imbedded(ii). Ensure that quality information is presented at relevant meetings.60 days |
| Criterion 1.2.3.8A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented. | PA Low | Bupa has a quality process that includes the use of corrective action plans where gaps in service provision were evidenced. Action plans have a specific template that allows for a description of the issue, the plan to address the issue and evaluations of progress. These were not always documented and not always followed up when in place. | (i). Action plans were not consistently documented following internal audits and resident/family survey.(ii). Action plans documented were not always documented as followed up and signed off. This included; internal audits and action plans following customer focus groups. | (i). Ensure that action plans are documented where a gap in service provision has been evidenced.(ii). Ensure that action plans are documented as followed up and signed off.90 days |
| Criterion 1.2.4.3The 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 | Bupa Gardenview has robust policies and procedures in place around incident and accident reporting, RN review and resident follow-up. RN follow-up to ensure resident safety/comfort was not always documented and one pressure injury had no incident form documented. | (i). RN follow-up was not documented for four incidents reviewed, including; two medication errors, one skin tear and one fall.(ii). One pressure injury did not have an incident form documented (corrected on day of audit). | (i). Ensure that all resident-related incidents have a documented RN review of the resident to ensure their ongoing safety and care and also to minimise further occurrences.(ii). Ensure all incidents are documented.30 days |
| Criterion 1.2.7.3The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | A register of practising certificates including all health professionals involved in the service is maintained. The service has a comprehensive orientation programme and annual education programme in place that provides staff with relevant information for safe work practice. All staff are expected to achieve the dementia unit standards within timeframes. Not all staff have the dementia unit standards; the new (acting) management team are working with staff who are yet to attain these qualifications. | Of the 43 staff that work at Gardenview; four caregivers, who have been employed for over two years, have not yet attained the dementia unit standards. | Ensure that all staff who work at Gardenview achieve the dementia unit standards within the required timeframes.90 days |
| Criterion 1.3.3.4The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate. | PA Low | Caregiver notes are detailed and reflect the residents’ overall movements throughout the shift. Overall progress notes were documented weekly in the resident files reviewed; however, the note only contained information around the issue on the day. There was no overview of important issues for the resident such as weight loss, wound cares, falls or behaviours.  | The weekly progress notes documented by the registered nurses did not reflect an overview of the week in all six resident files. | Ensure the weekly RN overview includes important issues of the resident over the weekly period. 90 days |
| Criterion 1.3.5.2Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process. | PA Low | Care plan interventions contained instructions to guide staff to provide adequate care for residents. There were very detailed instructions around management of diabetes, infections falls, and personal cares, however not all care plans reviewed were reflective of current resident condition. | (i) There were no individualised triggers, behaviours and de-escalation techniques identified for two of six files reviewed.(ii) There were no pressure relieving interventions documented in the care plans for two residents with pressure injuries.(iii) Not all preferences of a Māori resident were documented in the care plan.  | (i)-(iii) Ensure all care plan interventions are individualised and contain resident-specific information to meet all needs. 90 days |
| Criterion 1.3.6.1The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes. | PA Moderate | A wound care assessment, plan and evaluation with photos to evidence progression and deterioration of the wounds, however, not all wounds were identified correctly, and not all wound charts were completed as per policy, and the pressure injuries were not always correctly staged on assessment. A section 31 notification was sent on the day of the audit for the unstageable pressure injury identified by the Nurse Practitioner.  | (i). Two of two wound charts with pressure injuries did not always have an assessment or plan completed in a timely manner (gap of 11 days). (ii). Pressure injuries were not correctly staged on assessment in two of two pressure injuries reviewed.  | (i). Ensure wound assessment and plans are completed in a timely manner.(ii). Ensure wound assessments are completed in a timely manner. 90 days |
| Criterion 1.4.3.1There are adequate numbers of accessible toilets/showers/bathing facilities conveniently located and in close proximity to each service area to meet the needs of consumers. This excludes any toilets/showers/bathing facilities designated for service providers or visitor use. | PA Low | Shower curtains were installed in the shower areas to protect resident privacy, however, there were no privacy locks or privacy curtains installed in the toilets.  | None of the toilets have privacy locks or curtains to ensure resident privacy.  | Ensure residents privacy is maintained when using toilets.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.