

Oceania Care Company Limited - Greenvalley

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 Central Region's Technical Advisory Services 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:	Oceania Care Company Limited
Premises audited:	Greenvalley
Services audited:	Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 10 September 2020 End date: 11 September 2020
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:	41

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

Greenvalley is owned and operated by Oceania Healthcare Limited and provides rest home and dementia level care for up to 52 residents. Occupancy on the first day of audit was 41.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board.

The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family, management, staff, and a general practitioner.

Areas identified as requiring improvement relate to service provision requirements.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Residents and family are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights on admission. Services are provided that support personal privacy, independence, individuality and dignity.

All residents including those who identify as Māori have their needs met in a manner that respects their cultural values and beliefs.

Open communication between staff, residents and family is promoted, and confirmed to be effective. There is access to interpreting services if required. Informed consent is practised, and written consent is gained when required.

Residents were observed being treated in a professional and respectful manner. Policies are in place to ensure residents are free from discrimination, abuse and neglect.

A complaints register is maintained with complaints resolved promptly and effectively.

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.		Standards applicable to this service fully attained.
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Oceania Healthcare Limited is the governing body responsible for the services provided at the facility. The vision, mission and values of the organisation are documented and communicated to all concerned.

The facility adheres to the Oceania Healthcare Limited quality and risk management system that includes collection and analysis of quality improvement data, identifies trends and risk mitigation. All data collection and reporting follow a schedule. Meetings are held to discuss key clinical performance indicators, quality and risk issues, resident satisfaction and health and safety.

A business and care manager oversees the facility with the support of a regional clinical and quality manager and a regional operations manager. A clinical manager supervises clinical services. Both the business and care manager and the clinical manager are registered nurses.

The appointment, orientation and management of staff is based on current good practice. A systematic approach to identify and deliver ongoing training supports safe service delivery and includes regular individual performance review. Staffing levels and skill mix meet the changing needs of residents.

Residents' information is accurately recorded, securely stored and not accessible to unauthorised people.

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.
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The organisation works with the Needs Assessment Coordination Service to ensure resident's access to the service, whenever there is a vacancy.

The residents' needs are assessed on admission by registered nurses. Computerised residents' records provide evidence of documented residents' assessments, needs, goals and outcomes that are reviewed on a regular basis. Residents' initial care plans and short-term care plans for acute conditions are conducted within the required timeframes.

Nursing care plan evaluations are documented, resident-focused and indicate progress towards meeting the residents' desired outcomes. There is evidence that each stage of service provision is developed with resident and/or family input and coordinated to promote continuity of service delivery. The residents and family members interviewed reported being informed and involved, and satisfied with services provided.

The activities programme includes a wide range of activities and involvement with wider community. Residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

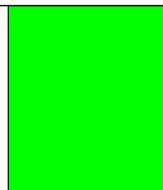
Residents are referred or transferred to other health services as required, with appropriate verbal and written handovers.

There is an appropriate medicine management system in place. Staff responsible for medicine management have current medication competencies. The residents self-administering medicines do so according to policy.

The menu has been reviewed by a registered dietitian as meeting nutritional guidelines for older people. There is a central kitchen and on-site staff that provide the food service. The residents verified satisfaction with meals.

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. Security systems are in place and staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills.

A reactive and preventative maintenance programme is implemented. Electrical equipment is tested as required.

Residents bedrooms are of an appropriate size for the safe use and manoeuvring of mobility aids if required and allow for care to be provided. Lounges, dining rooms and sitting alcoves are available for residents and their visitors. Communal and individual spaces are maintained at a comfortable temperature. A call bell system is available to allow residents to access help when needed.

Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are safely stored. Staff use protective equipment and clothing. Laundry is undertaken off site and evaluated for effectiveness. Cleaning of the facility is conducted and monitored by trained household staff.

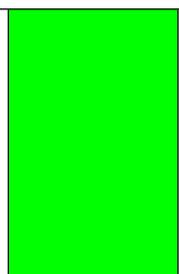
Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standards. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety.

There were no residents using restraint or requesting the use of enablers on audit days.

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.
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The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard.

The infection prevention and control programme is reviewed annually. New staff are provided with training and orientation in infection control practices and there is on-going infection control education available for all staff. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirmed that the surveillance programme is appropriate for the size and complexity of the services provided. The results of surveillance are reported through all levels of the organisation, including governance.

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	44	0	1	0	0	0
Criteria	0	92	0	1	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Greenvalley has implemented Oceania Healthcare Limited (Oceania) wide policies, procedures and processes to meet the facility's obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code).</p> <p>Training on the Code is provided as part of the orientation process for all staff and included in ongoing training, as was verified in training records. Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide guidance to staff. Residents interviewed and clinical files reviewed show that informed consent has been gained appropriately using the organisation's standard consent form. Advance care planning, establishing and documenting enduring power of attorney (EPOA) requirements and processes for residents who are unable to consent, are defined and documented, as relevant, in the resident's record.</p>

		Staff were observed to gain consent for day to day care.
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the advocacy service. Posters and brochures related to the advocacy service were also displayed and available in the facility. Family members and residents interviewed were aware of the advocacy service, how to access this and their right to have a support person.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility has restricted visiting hours, this is directly related to COVID-19 (level 2.5). Family are welcome if an appointment is made. Greenvalley encourages visits from residents' family and friends and under normal circumstances there is unrestricted visiting hours. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and family on admission and those interviewed knew how to make a complaint if should they need to do so.</p> <p>The complaints register reviewed showed that 3 complaints have been received over the past 18 months and that actions taken, through to an agreed resolution, are documented and completed within required timeframes. Action plans show any required follow up and improvements have been made where possible. The BCM is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required. Residents and family interviewed stated they would feel comfortable raising issues with staff and management.</p> <p>The BCM stated in interview that there have been no complaints with external agencies since the last audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents are provided with information about the Code and the Nationwide Health and Disability Advocacy Service (advocacy service) as part of the admission information provided and discussion on admission with staff.</p> <p>The Code is displayed throughout the facility together with information on advocacy services, how to make a complaint and feedback forms.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff were observed to maintain privacy throughout the audit. All residents have their own private room.</p> <p>Residents and family confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Residents are encouraged to maintain their independence by involvement with community activities, and participation in clubs of their choosing. Care plans reviewed included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff interviews described understanding of the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>There is a current Māori health plan that guides staff in meeting the needs of the residents who identify as Māori. Any additional cultural support, if required would be accessed locally. This was confirmed during an interview with the business and care manager (BCM) and clinical manager (CM).</p> <p>Residents, who identified as Māori interviewed reported that staff acknowledge and respect their individual cultural needs. Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs.</p>
<p>Standard 1.1.6: Recognition And Respect Of</p>	<p>FA</p>	<p>Residents' interviews verified that they were consulted on their individual culture, values</p>

<p>The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>and beliefs and that staff respected these. Resident's personal preferences requiring interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>Staff are guided by policies and procedures that outline the process to follow, should they suspect any form of exploitation. Interviews with staff demonstrated that they had a clear understanding of their obligations under the policy.</p> <p>The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct.</p> <p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>Greenvalley implements Oceania policies and procedures which are based on good practice, current legislation and relevant guidelines.</p> <p>The service encourages and promotes good practice through: evidence-based policies, input from external specialist services and allied health professionals. For example, district nurse wound care specialist, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and was responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access regular Oceania study days to support good practice.</p> <p>An example of good practice observed during the audit included the recent development of a sensory garden specifically for residents in the dementia unit.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Residents and family members stated they were kept well informed about any changes to their relative's status, and were advised in a timely manner about any incidents or accidents, and the outcomes of regular and any urgent medical reviews. This was supported in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>Residents and family are invited to take part in resident's meetings that occur monthly as</p>

		<p>seen in minutes.</p> <p>The need for access to interpreters is assessed on admission to the facility. Access to interpreters is organised through family members or the district health board (DHB).</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Greenvalley is owned and operated by Oceania with the board and executive team providing direction and support to the service. The organisation has vision, mission and value's in place which are resident centred. The organisation's values were displayed in the foyer of the facility. Oceania develops annual objectives for the quality of service delivery, performance and risks at a national level. The BCM reported the national objectives have been adopted at a facility level for 2020, this is related to the impact of COVID-19 on facilities. The BCM reports monthly to a regional operations manager on key performance indicators.</p> <p>The service is managed by a BCM who has been in the role for the past two years. The BCM was the CM at the facility for two years prior to this appointment. The CM was appointed to the position ten months ago, having had previous experience in rest homes in New Zealand for six years. Both BCM and CM are registered nurses (RNs) with current practicing certificates. The managers maintain their knowledge of the sector through representation and participation in aged care forums and seminars.</p> <p>The service provides hospital and rest home for up to 52 residents. The facility is certified for 32 rest home beds and 20 dementia level care beds.</p> <p>At the time of the audit, there were a total of 41 residents in the facility, 21 receiving rest home level care, 1 receiving respite care and 19 receiving dementia level care.</p> <p>Contracts with the DHB include rest home level care, dementia level care and respite care. There was 1 resident receiving respite care at the time of the audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>In the short-term absence of the BCM, the responsibilities of the BCM will be carried out by the CM, with support from the regional clinical quality manager (CQM) to ensure the day-to day operations of the facility.</p> <p>The CM is supported by senior RNs who can help cover leave if necessary.</p> <p>The CQM supports the BCM as needed and was observed doing so during the audit. The BCM reported that the current arrangements work well.</p>

<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities, a regular patient satisfaction survey, monitoring of outcomes and clinical incidents including infections. The system promotes collaboration between the senior management team, regional managers, CMs, staff and residents. Thereby ensuring monitoring and implementation of continuous quality improvement within the organisation. Oceania uses a range of audit and survey data to benchmark its service against other facilities in the network to improve quality and mitigate risk.</p> <p>The facility adheres to Oceania wide policies and procedures, which are current.</p> <p>A document control policy is in place. Staff are informed of policy changes at staff meetings and sign that they have read the changed documents and at interview staff confirmed the process.</p> <p>A range of quality activities are documented. This includes the collection of quality data including the results of internal audits, accidents/incidents reports, health and safety reporting, infection control data, restraint, complaints and resident satisfaction surveys. Clinical indicators are used in the Oceania benchmarking programme. Quality related information is shared with all staff as confirmed in meeting minutes sampled. Monthly residents meeting minutes sighted also confirm that resident feedback is sought and corrective actions put in place.</p> <p>Meeting minutes and internal audits are completed as per the annual planner. Meeting minutes reviewed confirmed that regular review and analysis of quality indicators and related information is reported and discussed at quality, health and safety and staff meetings.</p> <p>Issues are identified for improvements and an action plan is completed.</p> <p>A current hazard register identifies health and safety risks and risk ratings associated with different areas of the environment, service delivery and human resource management. The health and safety committee meets monthly to review findings and actions plans which includes a person responsible for the corrective action, a timeframe and an evaluation of the improvement outcomes.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p>	<p>FA</p>	<p>The BCM described essential notification reporting requirements, including for pressure injuries. They advised there have been 2 notifications of significant events made to the</p>

<p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>		<p>Ministry of Health, in the past 12 months. One for the appointment of the CM and the other relating to the norovirus outbreak in June 2020. Staff interviewed are aware of the organisation's policies and processes regarding reporting, notification and management of adverse events.</p> <p>Staff document adverse and near miss events in an electronic database system. A sample of lodged incidents reviewed showed these were fully completed, including notifying the residents family/EPOA, GP and emergency services when necessary. Staff interviewed commenced the process in the accident/incident electronic form, the registered nurse or CM then checks the data. Accidents/incidents were investigated, action plans developed and actions followed-up in a timely manner.</p> <p>The CM is responsible for reviewing clinical accidents/incidents. The BCM for is responsible for reviewing adverse events such as medication errors or those that have caused significant harm. The BCM is also responsible for investigating the event and developing a corrective action plan to mitigate future risks. Event data is collated, analysed and reported at staff meetings.</p> <p>A national level report is produced monthly and reported through a local level at staff meetings.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resources management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Health care assistants (HCA) staff have either completed or commenced a New Zealand Qualification Authority education programme that includes dementia, to meet the requirements of the provider's agreement with the DHB.</p> <p>The BCM, CM and two RN's are maintaining their annual competency requirements to undertake interRAI assessments.</p> <p>Records reviewed demonstrated completion of the required training and completion of</p>

		annual performance appraisals.
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, 7 days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents. An afterhours on call roster is in place, with staff reporting that good access to advice is available when needed. Health care assistants reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence.</p> <p>Greenvalley policy is to have all RN's, HCA, and drivers of the van with a current first aid certificate. Four staff were no longer current, this is directly related to the COVID-19 outbreak. Rescheduling of the course has occurred. A staff member with a current first aid certificate is rostered on each shift. There is a rostered RN on each morning shift, four HCAs on the morning shift, three HCA on the afternoon shift and three HCA's on each night shift.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>Resident progress notes are completed in the electronic patient management system every shift, detailing resident response to service provision and progress towards identified goals. Records were legible with the name and designation of the person making the entry identifiable. Residents files reviewed included relevant information on the residents' care and support information that could be accessed in a timely manner.</p> <p>There are policies and procedures in place to ensure privacy and confidentiality. Staff interviews described the procedures for maintaining confidentiality of resident's records. No personal or private resident information was on public display during the audit.</p> <p>Archived hard copy records are held securely on site and are readily retrievable. Residents' hard copy files are held for the required period before being destroyed.</p> <p>Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessments entered into the electronic database.</p>
<p>Standard 1.3.1: Entry To Services</p>	FA	Residents' entry into the service and the assessment processes are recorded and

<p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>implemented.</p> <p>The organisation works with the needs assessment and coordination service (NASC), to ensure access to the service is appropriate and efficiently managed. Data review confirmed that each potential resident is assessed using the interRAI home care assessment tool in the six months before date of their admission. The needs assessments are completed for rest home and dementia levels of care. The organisation obtains information from the NASC service and/or the GP for residents accessing respite care.</p> <p>Residents who have been assessed by the NASC service as requiring specialist dementia services are only admitted to the dementia unit.</p> <p>The facility information pack is available for residents and their family and contains all relevant information. New residents and family/whānau are provided with written information on the service philosophy and practices particular to the dementia unit as per the aged residential care (ARC) contract.</p> <p>The residents' admission agreements reviewed evidenced resident and/or family and facility representative sign off. In interviews, residents and family members confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>The resident's exit, discharge or transfer is managed in a planned and coordinated manner. There is appropriate communication between family and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required. At the time of transition, appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in the residents' computerised records.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>There is a computerised medication management system in place with appropriate processes implemented for the system to comply with current legislation requirements and safe practice guidelines. The medication areas evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced that weekly checks and six-monthly physical stock takes.</p>

		<p>Regular records of temperature checks for the medicine fridge have readings documenting temperatures within the recommended range.</p> <p>All staff authorised to administer medicines have current competencies. A medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and signed off, as the dose was administered.</p> <p>The residents self-administering medicines at the facility do so according to policy.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>There is a seasonal four-week cycle menu provided, that is in line with recognised nutritional guidelines for older people. The Oceania winter menu was approved in May 2020 by a registered dietitian.</p> <p>The service operates with a multi-site approved food control plan applicable to all Oceania facilities. Food temperatures are monitored and recorded as part of the food control plan. The food service staff have undertaken a safe food handling qualification and completed relevant food handling training.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The current residents' dietary profiles are communicated to the kitchen manager to inform them of the residents' dietary requirements. Residents' dietary profiles were in the main kitchen and the satellite kitchen to guide kitchen and care staff when serving food to residents.</p> <p>Special equipment, to meet residents' nutritional needs, was sighted. The dementia unit has availability of additional nutritious snacks over a 24-hour period, confirmed at management interviews. The residents' files demonstrated monthly monitoring of individual resident's weight.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p> <p>Evidence of resident satisfaction with meals is verified by residents' and family interviews, sighted satisfaction surveys and residents' meeting minutes.</p>

<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>There is a process to inform residents and their family, in an appropriate manner, of the reasons why the resident has been declined entry to the service. This would be implemented, if required. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p> <p>The residents would be declined entry if not within the scope of the service or if a bed was not available, confirmed at management interviews.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The residents' needs are assessed on admission to establish an initial care plan. The residents have their needs identified through a variety of information sources that include but are not limited to: the NASC interRAI home care assessments; GPs records; specialists communication; other service providers involved with the resident; the resident; and family. The residents' computerised records evidenced residents' completed discharge/transfer information from the DHB, where required.</p> <p>The assessments of residents with dementia include identifying behaviours particular to the resident. This information is gained from previous care givers and, where applicable, the resident's family/whānau or nominated representative.</p> <p>The computerised residents' records reviewed evidenced the interRAI assessments were completed within 21 days of the resident's admission and reviewed 6 monthly or earlier if required.</p> <p>Residents' assessments are conducted in a safe and appropriate setting including visits from the GP, allied health staff and specialists. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The assessment findings in consultation with the resident and/or family, inform the long-term care plan and describe the required support and interventions. Each resident has a long-term nursing care plan based on assessments carried out using the interRAI assessment tool.</p> <p>Residents' care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short-term care plans are developed, evaluated regularly and signed off when short-term problems are</p>

		<p>resolved.</p> <p>The long-term care plans of residents with dementia record prevention-based strategies for minimising episodes of challenging behaviours and descriptions of how the behaviours of the resident are best managed over a 24-hour period.</p> <p>In interviews, staff reported they receive adequate information for continuity of residents' care. The residents have input into their care planning and review. Regular GP care is implemented, sighted in current residents' progress reports and confirmed at GP interview.</p> <p>There was evidence, service integration is maintained with residents' computerised progress notes, that include: activities, medical and allied health professionals' notations.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>The documentation, observations and interviews verified the provision of care provided to residents was consistent with the residents' needs and their desired outcomes. The residents' care plans evidenced detailed interventions based on assessed needs, desired outcomes or goals of the residents.</p> <p>In interviews, residents and family confirmed that current care and treatments meet the resident's needs. Family communication is recorded in the computerised residents' records. Residents' computerised progress notes and observation charts are maintained (refer to 1.3.3.3).</p> <p>In interviews, staff confirmed they are familiar with the current interventions of the residents they were allocated.</p> <p>Review of wound management at the facility evidenced wounds are assessed, timely treatment is provided and evaluations occur to ensure wounds are improving or referred to a specialist when required.</p> <p>The facility has appropriate resources and equipment, confirmed at staff interviews and visual observation. The equipment available complied with best practice guidelines and met the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are</p>	FA	<p>The residents are assessed by diversional therapists (DTs) to ascertain their activity and social needs and appropriate requirements relating to planned activities. The residents' activities assessments are analysed to develop two activities programmes in the facility, one for the rest home residents and one for residents in the dementia unit. Review of the</p>

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>activities programmes evidenced the identified residents' skills, likes, dislikes and interests were reflected in the programmes.</p> <p>There are two DTs who are employed to plan, facilitate and evaluate the activities programmes. Activities are provided seven days a week with activities staff providing support to clinical staff over sun downing period in the dementia unit.</p> <p>In interviews, the DTs confirmed the activities programmes meet the needs of the service group and the service has appropriate equipment.</p> <p>Residents' and family members' surveys evaluate the activities programmes six-monthly. Review of the surveys evidenced satisfaction with the activities programmes.</p> <p>Regular exercises and outings are provided for those residents able to partake. The activities programmes include input from external agencies, when able and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations.</p> <p>There were current, individualised activities care plans in the computerised residents' records. The residents' individual activities goals were documented and specific activities interventions matched their goals.</p> <p>The residents with dementia have a description of the activities that meet the resident's needs in relation to individual diversional, motivational, and recreational therapy during the 24-hour period when challenging behaviours may occur. These activities reflect the resident's former routines and activities that are still familiar to the resident.</p> <p>The residents' activity needs are evaluated regularly, as part of the formal six-monthly care plan review. The residents' activities attendance records are maintained. Family/whanau and friends are welcome to attend all activities during non-restricted visiting times.</p> <p>The residents' meeting minutes evidence residents' involvement and consultation of the planned activities programmes.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Timeframes in relation to care planning evaluations are documented and implemented. Formal care plan evaluations, following reassessment to measure the degree of a resident's response in relation to desired outcomes and goals are carried out by the RNs and documented. Reassessments are completed using the interRAI assessments, every six months or when changes in resident's health status occurs. Residents with health status changes had completed reassessments using interRAI.</p>

		<p>There was evidence of resident, family, HCA, DT and GP input into care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews. The residents' care plans sighted were current.</p> <p>The residents' progress notes are entered on each shift and there is evidence residents' care is evaluated and reported on. If any change is noted, it is reported to the RN or the CM. When resident's progress is different than expected, the RN contacts the GP, as required. Confirmed at the GP interview.</p> <p>Short-term care plans are completed when required. A short-term care plan is initiated for short term concerns, such as infections, changes in mobility and the resident's general condition. Short-term care plans are reviewed as indicated by the degree of risk noted during the assessment process. Interviews verified residents and family are included and informed of all changes. Family interviews also confirmed that family are notified of any changes in a resident's condition.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Appropriate processes and supports are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication records confirmed family involvement. An effective multidisciplinary team approach is maintained and progress notes detail relevant processes are implemented.</p> <p>When required, referrals to non-urgent services are conducted by the GP or the RN. Copies of referrals including radiology; wound care specialist; mental health services for older persons and other health professionals, were sighted in residents' records reviewed. Referrals are followed up on a regular basis by the GP or the RN. The resident and the family are kept informed of the referral process, as verified by documentation and interviews.</p> <p>Acute/urgent referrals are attended to immediately, for example sending the resident to accident and emergency in an ambulance if the circumstances dictate. The GP interview confirmed they are informed of any acute changes in resident's condition and involved in acute referrals to DHB.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and provide relevant training for staff. Safety data sheets were available where chemicals are</p>

<p>waste, infectious or hazardous substances, generated during service delivery.</p>		<p>stored. Staff interviewed understood what to do should any chemical spill/event occur. There is provision and availability of protective clothing and equipment and staff were observed using this.</p>
<p>Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is publicly displayed. Buildings, plant, and equipment comply with relevant legislation.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment is current as confirmed in documentation reviewed, interviews with maintenance personnel and observation of the environment.</p> <p>Processes are in place to ensure the environment is hazard free, that residents are safe, and independence is promoted. For example, by the removal of equipment such as linen trolleys and cleaning equipment.</p> <p>External areas are safely maintained and are appropriate to the resident groups and setting.</p> <p>Residents' interviews confirmed they are aware of the processes to follow to report any required repairs or maintenance is required. They stated that any requests are appropriately actioned and that they are happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All rooms have a private toilet and handbasin. Seven rest home beds on the lower level have ensuite facilities. Four communal shower rooms are used in the rest home and dementia unit of the facility.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote resident independence.</p> <p>Hot water temperatures are monitored monthly. When hot water temperatures are above the recommended safe temperature action is taken and rechecking of the temperature occurs to ensure it is maintained at a safe temperature.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Two resident rooms on the lower level are of a size that could accommodate two residents, however, currently there is only one call bell system and no privacy curtains. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs, and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture is appropriate to the setting and residents' needs.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is undertaken off site by an external contractor. Dedicated laundry staff ensure all residents clothing is ironed and returned to the appropriate resident. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small designated cleaning team on each day of the week. All have received appropriate training in the use of chemicals for cleaning purposes. Chemicals are stored in a lockable cupboard in appropriately labelled containers. Sluice rooms are available for the disposal of soiled water and waste.</p> <p>Handwashing facilities and hand gel are available throughout the facility.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and describe the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service in 1988. A trial evacuation takes place with a copy sent to the New Zealand Fire Service, the most recent being in September 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency</p>

		<p>procedures.</p> <p>Supplies for use in the event of a civil defence emergency, including food, water, blankets, and a gas barbeque were sighted and meet the requirements of residents.</p> <p>Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and family reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked at a predetermined time.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light, opening external windows and/or ranch slider opening onto an outside area. Heating is provided by a variety of ways including heaters in residents' rooms and heat pumps in the communal areas. Areas were warm and well ventilated throughout the audit, and residents and family confirmed the facility are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>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.</p>	FA	<p>The facility's environment minimises the risk of infection to residents, staff and visitors by implementing an appropriate infection prevention and control programme.</p> <p>Oceania infection control committee (company wide) is led by the Oceania general manager, working in conjunction with the regional clinical and quality manager team. The organisation has a virtual group of infection control experts who meet monthly and have input into organisation infection control strategies, policies and procedure reviews, confirmed at regional clinical quality manager interview.</p> <p>The infection control nurse (ICN) who is the CM, has access to external specialist advice from: Oceania senior management; GPs and DHB infection control specialists when required. A documented role description for the ICN including role and responsibilities is in place.</p> <p>The infection control programme is reviewed annually. The annual review includes all standards relating to infection prevention and control. Infection prevention and control is incorporated in facility's meetings. Staff are made aware of new infections through daily handovers on each shift and residents' progress notes, confirmed at staff interviews.</p>

		<p>There are processes in place to isolate infectious residents when this is required.</p> <p>Hand sanitisers and gels are available throughout the facility for staff, residents and visitors to use. The facility has processes in place for contractors and visitors during COVID-19 levels.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN and the infection control team are responsible for implementing the infection control programme within the facility. The infection control team meets monthly and is comprised of: the ICN; BCM; RN; kitchen manager; cleaner and a HCA. The ICN has allocated time to implement the infection control programme within the organisation. Review of the infection prevention and control meeting minutes evidenced a standard agenda items covering: infection control clinical indicators; changes within the facility; personal protective equipment; infection control education; infection prevention and control audits; outbreak management and general business.</p> <p>Management interview indicated there are adequate human, physical, and information resources to implement the infection prevention and control programme. Infection control reports are discussed at the management quality meetings and monthly staff meetings. The ICN has access to all relevant resident data to undertake surveillance, internal audits and investigations respectively.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The organisation has documented policies and procedures in place that reflect current best practice. The infection control policies and procedures manual was last reviewed in March 2020. Additional policies and procedures manuals are available specific for COVID-19 guidelines.</p> <p>Staff were observed to be in compliance with the infection control policies and procedures. Staff demonstrated knowledge on the requirements of standard precautions and were able to locate policies and procedures.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>New staff are required to undertake orientation that includes infection prevention and control, evidenced in review of staff files. Staff education on infection prevention and control is conducted by ICN and external specialists. Staff interviewed confirmed an understanding of how to implement infection prevention and control activities into their everyday practice. The ICN has attended external infection control education in 2019.</p>

		Oceania support office and regional CQM have been supporting the facility during COVID-19 pandemic.
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>The ICN maintains infection logs for residents' infection events. Residents' files evidenced the residents' who were diagnosed with an infection had short-term care plans in place. The GP is informed in a timely manner when a resident has an infection and appropriate antibiotics are prescribed to combat the infection respectively.</p> <p>Monthly surveillance analysis is completed and reported at monthly staff meetings and entered in the clinical indicators on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board monthly.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents' computerised records.</p> <p>In interviews, the ICN and management confirmed there was an outbreak at the facility in May 2020. There was evidence this was reported to the required authorities and managed according to the Oceania outbreak management process.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Restraint minimisation and safe practice policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. On the days of the audit there were no residents using restraint or requesting the use of enablers.</p> <p>The restraint coordinator is the CM who demonstrated knowledge of the organisation's policies, procedures and practices relating to restraint and enabler use. A signed position description for the restraint coordinator was sighted.</p> <p>Oceania national restraint authority group annual meeting was conducted in April 2020. The minutes of this meeting confirmed review of restraint practices across Oceania facilities was completed and evidenced reduction of restraint use nationally. Greenvally remained restraint free in 2019. The restraint register evidenced restraint has also not been used at the facility in 2020.</p> <p>Clinical staff interviews confirmed enablers would be used voluntarily at a resident's request.</p>

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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	<p>Residents’ weight is monitored and recorded monthly. Review of the computerised residents’ records which include: vital signs, observations evidenced, the monthly observations of residents’ temperatures, pulse and respiratory rate, and blood pressure were not always completed.</p> <p>Food fridge temperature monitoring is completed in the kitchen. A resident’s food fridge located in a resident’s room was set at a designated temperature and had been checked for electrical safety. However, regular temperature monitoring had not occurred.</p>	<p>i) Residents’ monthly vital signs observations are not consistently completed.</p> <p>ii) Resident’s food fridge is not regularly monitored to ensure it is within the required temperature range.</p>	<p>i) Ensure residents’ vital signs are completed monthly.</p> <p>ii) Ensure regular temperature monitoring occurs for resident’s food fridge.</p> <p>60 days</p>

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, there 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.