

# North Care Limited - Lester Heights Hospital

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## 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 The DAA Group 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:

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| <b>Legal entity:</b>  | North Care Limited   |
| <b>Premises audited:</b>  | Lester Heights Hospital  |
| <b>Services audited:</b>  | Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Residential disability services - Physical |
| <b>Dates of audit:</b>  | Start date: 28 January 2021      End date: 29 January 2021   |
| <b>Proposed changes to current services (if any):</b>   | None   |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 33   |

# Executive summary of the audit

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## 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   |
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|   | 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  |
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|           | 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

Lester Heights Hospital provides rest home and hospital level care and non-aged residential care to young people with physical and/or intellectual disabilities for up to 35 residents. The service is operated by Northcare Ltd and managed by a facility manager and a clinical manager. Residents and families spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board and the Ministry of Health. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, family members, managers, staff and a general practitioner.

This audit has identified one area requiring improvement relating to activity planning.

## 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. |  | Standards applicable to this service fully attained. |
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Residents and families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumer Rights' (the Code) and these are respected. Services provided support personal privacy, independence, individuality, and dignity. Staff interacted with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and was confirmed to be effective. Additional communication devices and other aides are provided to young people with disabilities (YPD). There are systems in place to ensure family/whanau are provided with appropriate information to assist them to make informed choices on behalf of the residents.

The residents' cultural, spiritual, and individual values and beliefs are assessed and acknowledged. The service has linkages with a range of specialist health care providers to support best practice and meet rest home, hospital level of care and YPD residents' needs.

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

## Organisational management

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| 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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Business and quality and risk management plans included the direction, goals, values and philosophy of the organisation. These included appropriate references to the young people with disabilities who are residents. Monitoring of the services provided to the owner/director were regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery to all residents, including those young people with disabilities, and were current and reviewed regularly.

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 kept securely with all entries legible and designated.

## 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 low risk. |
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Policies and procedures provide documented guidelines for access to service. Residents are assessed prior to entry to the service to confirm their level of care. The registered nurses (RNs) are responsible for assessment, development, and evaluation of care plans. Care plans are individualised and based on the residents' assessed needs and routines. Interventions are appropriate and evaluated in a timely manner.

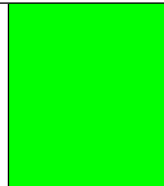
The service provides planned activities that meet the needs and interests of the residents as individuals and in group settings. YPD residents have a specific activity programme.

There is a medicine management system in place. Three monthly medication reviews are conducted by the general practitioner (GP) and these were current. Staff involved in medication administration are assessed as competent to do so. YPD residents are encouraged and supported with self-administering of medicines as per their preference.

The food service provides and caters for residents. Specific dietary likes and dislikes are accommodated. Residents' nutritional requirements are met.

## Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.



Standards applicable to this service fully attained.

The facility generally meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide some shade and seating. There are communal spaces that can be organised to provide specific areas for young people with disabilities as required.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Personalised equipment for young people with disabilities is well maintained and safely stored in their rooms. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. The service's emergency plan considers the special needs of young people with disabilities in an emergency with well documented individual assistance requirements. Fire evacuation procedures are regularly practised. Residents reported a timely staff response to call bells. Security is maintained.

## 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.

The organisation has implemented policies and procedures that support the minimisation of restraint. Seven enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Two restraints were in use. A comprehensive assessment, approval and monitoring process with regular reviews occurs. Staff demonstrated a sound knowledge and understanding of the restraint and enabler processes.

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

## Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

| Attainment Rating | Continuous Improvement (CI) | Fully Attained (FA) | Partially Attained Negligible Risk (PA Negligible) | Partially Attained Low Risk (PA Low) | Partially Attained Moderate Risk (PA Moderate) | Partially Attained High Risk (PA High) | Partially Attained Critical Risk (PA Critical) |
|-------------------|-----------------------------|---------------------|--|--------------------------------------|--|--|--|
| <b>Standards</b>  | 0                           | 49                  | 0  | 1                                    | 0  | 0                                      | 0  |
| <b>Criteria</b>   | 0                           | 100                 | 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) |
|-------------------|--|------------------------------|--|--------------------------------|--|
| <b>Standards</b>  | 0  | 0                            | 0                                      | 0                              | 0                                      |
| <b>Criteria</b>   | 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>Lester Heights Hospital has policies and procedures to meet their obligation in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff and ongoing training was verified in the training records. The last training was held on 30 September 2020. The Code is displayed around the facility.</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 relevant guidance to staff. Clinical files sampled showed that informed consent had been gained appropriately using the organisation's standard consent form. These are signed by the enduring power of attorney (EPOA) and the general practitioner makes a clinically based decision on resuscitation authorisation.</p> <p>Staff were observed to gain consent for day-to-day care. Interviews with relatives confirmed the service actively involves them in decisions that affect their family members' lives.</p> |

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| <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>       | <p>FA</p> | <p>As part of the admission process residents and family/whanau are given a copy of the Code, which includes information on advocacy services. Posters and brochures related to the national advocacy service were displayed and available in the facility. Family members were aware of the advocacy service, how to access this and their right to have support persons. The CM and staff provided examples of the involvement of advocacy services in relation to residents' care.</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> | <p>FA</p> | <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. Young people with a disability are assisted in accessing community resources and mainstream supports. Family/whanau or friends are encouraged to visit or call. YPD specific day rides to places of interest are arranged. The van has wheelchair access to accommodate them.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their encounters 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>                                 | <p>FA</p> | <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 families on admission and those interviewed knew how to do so.</p> <p>The complaints register reviewed showed that four complaints have been received over the nine months since the new owner took over the facility and that actions taken, through to an agreed resolution, are documented and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible. The facility manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of</p>  | <p>FA</p> | <p>Information about the consumer rights legislation, advocacy services and the complaints process are provided on admission and displayed at the reception. The Code is available in Maori and English. Family members interviewed were aware of consumer rights and confirmed that information was provided to them during the admission process.</p>   |

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| <p>their rights.</p>   |           | <p>The information brochure outlines the services provided. Resident agreements signed by an enduring power of attorney (EPOA) were sighted in records sampled. Service agreements meet the district health board requirements.</p>   |
| <p>Standard 1.1.3:<br/>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 respect and allow young people living with disabilities to express their personal, gender, sexual, cultural, religious, and spiritual identity. The residents' privacy and dignity are respected. Staff were observed maintaining privacy. Residents are supported to maintain their independence with the residents able to come and go within the building and around the secure grounds as they please. Records sampled 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>There is an abuse and neglect policy and staff interviewed understood how to report such incidents if suspected or observed. The clinical manager (CM) reported that any allegations of neglect, if reported, would be taken seriously and immediately followed up. There were no documented incidents of abuse or neglect in the records sampled. Family members expressed no concerns regarding abuse, neglect, or culturally unsafe practice.</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>Assessments and care plans document any cultural/spiritual needs. Special consideration of cultural needs is provided in the event of death as described by staff. The required activities and blessings are conducted when and as required. All staff receive cultural awareness training. The cultural needs of six residents who identify as Maori had been considered. There were three staff members of Maori descent. Policies and procedures regarding the recognition of Maori values and beliefs are documented.</p>  |
| <p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual</p>                                | <p>FA</p> | <p>Cultural needs are determined on admission and a care plan is developed to ensure that care and services are delivered in a culturally and/or spiritually sensitive manner in accordance with protocols/guidelines as recognised by the family/whanau. Values and beliefs are discussed and incorporated into the care plan. Family members confirmed they are encouraged to be involved in the development of the long-term care plans. Residents' personal preferences and special needs were included in care plans reviewed.</p>   |

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| values, and beliefs.  |    |  |
| <p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>              | FA | <p>Family members stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the code of conduct. All staff sign a code of conduct statement. Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. The CM stated that there have been no reported alleged episodes of abuse, neglect, or discrimination towards residents.</p>  |
| <p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>  | FA | <p>The service encourages and promotes good practice through ongoing professional development of staff. Policies and procedures are linked to evidence-based practice. The general practitioner (GP) confirmed promptness and appropriateness of medical intervention when medical requests are sought. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice. The organisation supports nursing student placements, however there were no nursing students on placement from the local university on the days of the audit due to current Covid-19 pandemic restrictions.</p>  |
| <p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p> | FA | <p>Interviews and records sampled confirmed that residents and family/whanau are accorded the right to full and frank information or open disclosure. The environment is conducive to effective communication and interpreter services are provided if required. Policies and procedures are in place if the interpreter services are needed.</p> <p>There are alternative forms of communication that meet the needs of young people with disability. These include various community groups such as, Talk-link Trust, interpreters for the deaf and staff members can use basic sign language including communication cards. Staff have received education on appropriate communication methods.</p> <p>Documentation regarding open disclosure following incidents/accidents was evident.</p> |
| <p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate</p>                            | FA | <p>The business and quality plans, which are intended to be reviewed annually, outline the purpose, values, direction and goals of the organisation. The documents described annual and longer-term objectives and the associated operational plans. Planning for young people with disabilities is included in relevant policy and procedural documents and reflect a person/family centred approach. A sample of monthly and quarterly reporting to the director/owner showed adequate information to monitor performance is reported including</p>  |

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| <p>to the needs of consumers.</p>   |           | <p>relevant quality and occupancy data and any issues arising.</p> <p>The service is managed by a facility manager who holds relevant qualifications and has been in the role for six months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through relevant training. She also has nursing registration.</p> <p>The service holds contracts with the DHB for hospital and rest home level aged care and respite care and MoH for non-aged residential -YPD contract for young people with physical and/or intellectual disabilities. Thirty-three residents were receiving services under the contracts (three respite, 11 YPD's, 18 hospital level and 1 rest home level) at the time of 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> | <p>FA</p> | <p>If the facility manager is absent, either the owner or the group quality manager would carry out all the required duties under delegated authority. Due to the length of time the manager has been in the role, there have not yet been any absences. During any absences of key clinical staff, the clinical management is overseen by the clinical group manager who is experienced in the sector and able to take responsibility for any clinical issues that may arise. Staff reported 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 resident and family satisfaction survey, monitoring of outcomes, clinical incidents including infections, falls and pressure injuries. Specific meetings and satisfaction surveys for young people with disabilities include ensuring they have input to quality improvements and feel they are included in decisions around personal technology, aids and equipment provided.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the management/RN team meetings and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities, staff survey and regular meetings where quality issues are discussed. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family satisfaction surveys are completed annually. The most recent survey in December reflected positive responses for most areas and showed a small number of concerns regarding food. These were addressed by way of discussions with the chef and the individual residents. The food service has shown improvement since the last audit. The younger residents are enjoying</p> |

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|   |    | <p>more appropriate activity programmes for them and are now having separate meetings with their group to discuss relevant items. They also have electronic equipment and all necessary aids to help mobility and independence.</p> <p>Policies reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process with the NASC requirements for young people. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents.</p> <p>The owner/director and facility manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>   |
| <p>Standard 1.2.4: Adverse Event Reporting</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> | FA | <p>Staff document adverse and near miss events on an accident/incident form. A sample of incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner. Adverse event data is collated, analysed and reported to the owner/director. A new group quality manager is now in place and will manage the reporting process in this area in the future.</p> <p>The facility manager described essential notification reporting requirements, including for pressure injuries. They advised there has been one notification of a significant event made to the Ministry of Health, since the previous audit. This has been resolved appropriately.</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>   | FA | <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 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 showed documentation of completed orientation and a performance reviews annually or earlier if indicated. These were all current.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB. Staff working with younger people have either completed, or are due to complete, specific training in working with younger residents. There are sufficient</p> |

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|   |    | trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of 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, seven 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. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of five two-weekly roster cycles confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate and there is 24/7 RN coverage in the hospital.</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>The residents' records are held both electronically and paper based. Staff have individual passwords to the residents' records data base, such as the medication management system and on the interRAI assessment tool. The visiting GP and allied health providers also have access to the system which supports integration of residents' records.</p> <p>Some residents' records are maintained in hard copy. This includes the admission agreement, consent agreements and the current care plan. All hard copies are kept securely in the locked cupboards. Hard copy archived records are stored safely and securely on site. There is an effective system for retrieving both hard copy and electronically stored residents' records.</p> <p>All records sampled were legible, included the time and date, and the designation of the writer. Progress notes were documented for each shift.</p> |
| <p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | FA | <p>The entry to service policy includes all the required aspects on the management of enquiries and entry. Lester Heights Hospital's information pack contains all the information about entry to the service. Assessments and entry screening processes are documented and clearly communicated to the family/whanau of choice where appropriate, local communities and referral agencies. Completed, Needs Assessment and Service Coordination (NASC) authorisation forms for both rest home, hospital level of care and YPD residents were sighted.</p> <p>Records reviewed confirmed that admission requirements are conducted within the required time frames and are signed on entry. Family/whanau interviewed confirmed that they received sufficient information regarding</p>  |

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|   |    | the services to be provided.   |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer<br><br>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.               | FA | There is a documented process for the management of transfers and discharges. A standard transfer form notification from the DHB is utilised when residents are required to be transferred to the public hospital or another service. Residents and their families are involved in all exit or discharges to and from the service and there was sufficient evidence in the residents' records to confirm this.   |
| Standard 1.3.12: Medicine Management<br><br>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | FA | <p>The medication management policy identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. The service uses an electronic management system for medication prescribing, dispensing, administration, review, and reconciliation. Indications for use are noted for 'as required' medications, allergies are clearly indicated, and photos were current. Administration records are maintained, and drug incident forms are completed in the event of any drug errors. The medication and associated documentation are in place. Medication reconciliation is conducted by the RNs when a resident is transferred back to the service from hospital or any external appointments. The RNs check medicines against the prescription, and these were updated in the electronic management system. The GP completes three monthly reviews.</p> <p>There were no expired or unwanted medicines and expired medicines are returned to the pharmacy in a timely manner. Monitoring of medicine fridge temperatures is conducted regularly and deviations from normal were reported and attended to promptly. Monitoring of medication fridge and room temperature was maintained. The RN was observed administering medications safely and correctly. Medications were stored in a safe and secure way in the trolley and locked storeroom. Medication competencies were completed annually for all staff administering medication. Medication audit was conducted 20 November 2020 and corrective actions were completed.</p> <p>There were no residents self-administering medications. There is a policy and procedure for self-administration of medication if required. Self-administration of medicines is encouraged for YPD residents who wish to do so if appropriate. There were YPD residents who could self-administer their medicines and the CM was in the process of reviewing the procedure with them. Weekly and six-monthly controlled drug stock takes were conducted, and this was confirmed on previous entries. Outcomes of pro re nata (PRN) were documented.</p> |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid  | FA | There is an approved food plan for the service. The kitchen service is run by a qualified chef and part time cook. There is a kitchen manager who oversees three other sister facilities. The residents have a diet profile  |



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| <p><b>Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>   |           | <p>developed on admission which identifies dietary requirements, likes, and dislikes and is communicated to the kitchen including any recent changes made. Residents are provided with alternative meals when needed. Diets are modified as required and the cook confirmed awareness on dietary needs of the residents. There is a six-weekly rotating winter and summer menu in place. Meal services are prepared on site and served in the allocated dining rooms. Meals are served warm in sizeable portions required by residents and any alternatives are offered as required.</p> <p>The residents' weights are monitored monthly and supplements are provided to residents with identified weight loss issues. Snacks and drinks are available for residents who wake up during the night. The family members and residents interviewed acknowledged satisfaction with the food service.</p> <p>The kitchen was registered under the food control plan and the registration expires 31 March 2021. The kitchen and pantry were sighted and observed to be clean, tidy, and stocked. Labels and dates were on all containers. Records of food temperature monitoring, fridges and freezers temperatures were maintained. Regular cleaning is conducted. All kitchen staff have completed food safety training and documents were sighted.</p> |
| <p><b>Standard 1.3.2: Declining Referral/Entry To Services</b></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>The CM reported that all consumers who are declined entry are recorded and when entry is declined relatives are informed of the reason for this and made aware of other options or alternative services available. The consumer is referred to the referral agency to ensure the person will be admitted to the appropriate service provider.</p>   |
| <p><b>Standard 1.3.4: Assessment</b></p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | <p>FA</p> | <p>Residents have their level of care identified through the needs assessment by the NASC agency. Initial assessments were completed within the required time frame on admission while residents' care plans and interRAI are completed within three weeks according to policy. Assessments and care plans are detailed and include input from the family/whanau and other health team members as appropriate. Additional assessments were completed according to the need (e.g., behavioural, nutritional, continence, and skin and pressure assessments). The RNs utilise standardised risk assessment tools on admission. In interviews conducted family/whanau expressed satisfaction with the assessment process.</p>   |

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| <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/whanau, informs the care plan and assists in identifying the required support to meet residents' goals and desired outcomes. The care plans sampled were resident focused and individualised. Short term care plans were used for short-term needs. Family/whanau confirmed they were involved in the care planning process. Residents' files demonstrated service integration and evidence of allied healthcare professionals involved in the care of the residents, such as the mental health services for older people, district nurses, dietitian, and GP.</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>  | <p>FA</p> | <p>All care plans reviewed evidenced that interventions were adequate to address the identified needs of residents. Significant changes were reported in a timely manner and prescribed orders carried out. The registered nurse reported that the GP's medical input was sought within an appropriate timeframe, that medical orders were followed, and care was person centred. Care staff confirmed that care was provided as outlined in the care plan. A range of equipment and resources are available, suited to the levels of care provided and in accordance with 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 appropriate to their needs, age, culture, and the setting of the service.</p> | <p>FA</p> | <p>The planned activities were appropriate to the residents' needs and abilities. The service has an activity programme in place that covers rest home, hospital and YPD residents. The activities were based on assessment and reflected the residents' social, cultural, spiritual, physical, cognitive needs/abilities, past hobbies, interests, and enjoyments. Social and recreational assessments were completed within two weeks of admission in consultation with the family/whanau. The activities were conducted by the DT with help from the assistant activities coordinator. The DT in consultation with the FM, CM and assistant activities coordinator were involved in developing a monthly planner which was posted on the notice boards and given to all residents. These were offered from Monday to Sunday. Activities included music therapy, board games, indoor bowl, morning walk, skittles, in-house church services, bingo, one on one interactions, ball games, pampering sessions, movies, arts, and craft. YPD residents have a quality-of-life plan developed and a specific YPD activity programme was sighted. Specific outings for young people with disabilities to areas of choice are arranged and these are conducted three times a week, with the exception of during the Covid-19 lockdown period.</p> <p>Residents' files had a documented activity care plan that reflected their preferred activities of choice, however evaluations were not in sync with interRAI assessments (Refer to 1.3.8.2). The residents were observed to be participating in a variety of activities on the audit day. The planned activities and community connections are suitable for the residents. There are regular outings/drives, for all residents (as appropriate). Residents interviewed reported overall satisfaction with the level and variety of activities provided.</p> |

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| <p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>  | <p>PA Low</p> | <p>The RNs and health care assistants complete progress notes on every shift or more frequently, as necessary. All noted changes by the HCAs were reported to the RNs in a timely manner. Where progress was different from expected, the service responded by initiating changes to the service delivery plan. Interviews verified residents and family/whanau were included and informed of all changes.</p> <p>An improvement is required to ensure evaluation of activity care plans are in sync with interRAI assessments.</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>Residents and family/whanau are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP and RNs sends a referral to seek specialist service provider assistance from the DHB. Referrals are followed up on a regular basis by the RNs, CM, facility manager (FM) or the GP. The resident and the family are kept informed of the referral process, as verified by documentation and interviews. Acute or urgent referrals are attended to and the resident transferred to public hospital in an ambulance if required.</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 waste, infectious or hazardous substances, generated during service delivery.</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. Any chemical handlers have all had appropriate training. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals were stored and staff interviewed knew what to do should any chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this.</p> |
| <p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible</p>  | <p>FA</p>     | <p>A current building warrant of fitness (expiry date 1 December 2021) was publicly displayed.</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 was current as confirmed in documentation reviewed, interviews with maintenance personnel and</p>   |

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| <p>physical environment and facilities that are fit for their purpose.</p>  |           | <p>observation of the environment. The environment was hazard free and resident safety was promoted. Personalised equipment is available for the young residents with disabilities to meet their mobility and equipment needs. Further assessment by the specialised communication agency to look at options for more communication assistance for two of the younger residents is recommended.</p> <p>External areas are safely maintained and were adequate to the resident groups and setting. Young people with disabilities are able to access all areas of the facility. Further development of outside areas is planned.</p> <p>Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are actioned. Residents and family members were happy with the environment.</p> |
| <p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>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. This includes six toilets and six showers. Appropriately secured and approved handrails are provided in the toilet/shower areas with upgrading planned. Other equipment/accessories are available to promote residents' independence.</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. Rooms are personalised with furnishings, photos and other personal items displayed. Some rooms are larger than others and these are allocated to residents according to assessed need.</p> <p>There is room to store mobility aids and wheelchairs. Staff and residents reported the adequacy of bedrooms.</p>   |
| <p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</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. Young people with disabilities are</p>  |

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| <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>   |           | <p>catered for with areas being able to be set aside for their meetings and any other events. Further development of an area specifically for the younger residents is underway. There is consideration of their compatibility with residents.</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 on site in a dedicated laundry having been brought back in-house following discussions with residents with some cultural concerns using an outside contractor. Family members would also assist if requested. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of soiled linen. 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 who have received appropriate training and monitoring. Chemicals were stored in a lockable cupboard and were in appropriately labelled containers.</p> <p>Cleaning and laundry processes are monitored through the internal audit programme and on-site individual work with the staff.</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 were displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The service's emergency plan has considered the special needs of young people with disabilities. The current fire evacuation plan was approved by the New Zealand Fire Service on the 21 July 2001. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 24 September 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and a gas BBQ were sighted and meet the National Emergency Management Agency recommendations for the region. Sufficient water is stored in large containers, with trays of drinking bottles also stored. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Doors and windows are locked and checked at a predetermined time at night.</p> |

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| <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 Heating is provided by wall heaters in residents' rooms and heat pumps in the communal areas. Fans have been installed in rooms to provide cooling in the summer. Areas were cool and well ventilated throughout the audit and residents and families confirmed the facilities 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>There is a documented infection prevention and control programme. The programme is reviewed annually. The review includes a review of the last year's annual infection control data, plus training, internal audits and policies and procedures. The review is completed by the CM and RN, and the report is shared with staff and in management meetings. The CM and RN share the role of the infection prevention and control coordinator (ICC). The position descriptions for both was well defined.</p> <p>Exposure to infection is prevented in several ways. The organisation provides relevant training, there was adequate supplies of personal protective equipment (PPE) and hand sanitisers. Hand washing audits are completed, the required policies and procedures are documented, and staff are advised to not attend work if they are unwell. Flu vaccines are offered to all staff and residents.</p> <p>There was a pandemic outbreak plan in place. Information and resources to support staff in managing COVID-19 was regularly updated. Visitor screening and residents' temperature monitoring records depending on alert levels by MOH were documented. The organisation now has a well-documented COVID-19 process.</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</p>                                 | FA | <p>The CM and RN are responsible for implementing the infection control programme and indicated there are adequate human, physical, and information resources to implement the programme. Infection control reports are discussed at management and staff meetings. The ICCs have access to all relevant resident data to undertake surveillance, internal audits, and investigations, respectively. Specialist support can be accessed through the district health board, the medical laboratory, and the GP.</p>   |

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| <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 service has documented policies and procedures in place that reflect current best practice. Staff were observed to be following the infection control policies and procedures. Care delivery, cleaning, laundry, and kitchen staff were observed following organisational policies, such as appropriate use of hand-sanitisers, good hand washing technique and use of disposable aprons and gloves. 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>Staff training on infection prevention and control is routinely provided during orientation and annually in in-service education. In-service education is conducted by either the CM or RN. The following training was provided in 2020: outbreak/pandemic policy and procedure training; hand washing procedure and infection prevention and control. Records of staff education are maintained.</p>   |
| <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 surveillance programme is defined and appropriate to the size and scope of the service. Infection data is collected, monitored, and reviewed monthly. The data is collated and analysed to identify any significant trends or common possible causative factors. Records of the previous three-monthly benchmarking with far north quality benchmarking group involving other eight facilities were sighted. Staff interviewed reported that they are informed of infection rates at staff meetings and through compiled reports. The GP is informed within the required time frame when a resident has an infection and appropriate antibiotics are prescribed for all diagnosed infections.</p> |
| <p>Standard 2.1.1: Restraint</p>   | FA | <p>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. The restraint coordinator provides support</p>  |

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| <p>minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  |    | <p>and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, two residents were using restraints and seven residents were using enablers, which were the least restrictive and used voluntarily at their request. A similar process is followed for the use of enablers as is used for restraints.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the RN meeting minutes, files reviewed, and from interviews with staff.</p>  |
| <p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p> | FA | <p>The approval of the use of restraints is discussed with the restraint coordinator, senior RN's and the GP who has signed all relevant approvals. Due to the on-going small number of restraints being used, there is no specific restraint committee in place. It was evident from review of residents' files and interviews with the coordinator that there are clear lines of accountability, that all restraints have been approved, and the overall use of restraints is being monitored and analysed.</p> <p>Evidence of family/whānau/EPOA involvement in the decision making was on file in each case. Use of a restraint or an enabler is part of the plan of care.</p>   |
| <p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>  | FA | <p>Assessments for the use of restraint were documented and included all requirements of the Standard. The restraint coordinator, who is also the clinical nurse manager, undertakes the initial assessment and input from the resident's family/whānau/EPOA. The interviewed restraint coordinator described the documented process. Families confirmed their involvement. The general practitioner is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p> |
| <p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>  | FA | <p>The use of restraints is actively minimised, and the restraint coordinator described how alternatives to restraints are discussed with staff and family members including the use of sensor mats and low beds which has already seen a reduction in restraint numbers.</p>  |



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|   |    | <p>When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are respected.</p> <p>A restraint register is maintained, updated every month and reviewed at each RN meeting. The register was reviewed and contained all residents currently using a restraint and enough information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as positively supporting people with challenging behaviours. Staff spoken to understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>   |
| <p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>   | FA | <p>Review of residents' files showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the relevant meetings. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p> <p>The evaluation covers all requirements of the Standard, including future options to eliminate use, the impact and outcomes achieved, if the policy and procedure was followed and documentation completed as required.</p>   |
| <p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p> | FA | <p>The restraint coordinator undertakes a six-monthly review of all restraint use which includes all the requirements of this Standard. Six monthly reports are completed, and individual use of restraint use is reported to the RN and staff meetings. Minutes of meetings reviewed confirmed this included analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint / enabler education and feedback from the doctor, staff and families. A six-monthly internal audit also informs these meetings. Any changes to policies, guidelines, education and processes are implemented if indicated. Data reviewed, minutes and interviews with the owner/director and the restraint coordinator confirmed that the use of restraint has reduced over the past 10 months since the new owner took over the facility.</p> |

## 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)  |
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| <p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p> | PA Low            | <p>Formal care plan evaluations, following reassessment to measure the degree of a resident’s response in relation to desired outcomes and goals occurred every six months or as residents’ needs change. These were carried out by the RNs in conjunction with family, the GP and specialist service providers. Short term care plans were reviewed weekly or as indicated by the degree of risk noted during the assessment process.</p> <p>Review/evaluation of individual activities plans were completed six-monthly, but not evaluated following interRAI assessments.</p> | Five out of six activity plans were evaluated without interRAI assessments outcome input. | <p>Provide evidence that activity plans are evaluated/reviewed following interRAI assessments.</p> <p>90 days</p> |

## Specific results for criterion where a continuous improvement has been recorded

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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.

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End of the report.