

Westmar 2021 Limited - Westmar 2021

Introduction

This report records the results of a Provisional 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 BSI Group New Zealand Ltd, 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: Westmar 2021 Limited

Premises audited: Westmar 2021

Services audited: Rest home care (excluding dementia care); Dementia care

Dates of audit: Start date: 4 March 2021 End date: 5 March 2021

Proposed changes to current services (if any): The provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The intended date of purchase is 1 May 2021.

Total beds occupied across all premises included in the audit on the first day of the audit: 24

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.

General overview of the audit

Westmar Senior Care (Ltd) provides rest home and dementia level of care for up to 28 residents. On the day of the audit there were 24 residents in total.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The provisional audit was conducted against the health and disability services standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, GP, staff, managers and prospective owners.

The owner/manager is supported by an assistant manager (Diversional Therapist) in the responsibility of the daily operations and overseeing the delivery of services. The management team are also supported by two registered nurses who job share and provide cover for each other.

The prospective owners also own and manage another rest home care facility in Christchurch. Both of the prospective owners are registered nurses with experience in aged care management and working with residents with dementia. It is intended that one of the prospective owners will take over the owner/manager's role at Westmar. A transition plan has been developed to ensure a smooth transition for staff under the new ownership. The prospective owners stated that their governance and quality management system, and policies and procedures will be reviewed with an independent quality management systems provider (approximately three to six months). There will be no proposed changes to the existing staff.

The following shortfalls were identified at this provisional audit around adverse events, first aid training, care plans, medication management, controlled drugs and safe and effective environment.

Consumer rights

Staff at Westmar Senior Care ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and services is easily accessible to residents and families. Information on informed consent is provided and discussed with residents and relatives. Staff interviewed are familiar with processes to ensure informed consent. Complaint's policies and procedures meet requirements and residents, and families are aware of the complaints process.

Organisational management

Organisational performance is monitored through a number of processes to ensure it aligns with the identified values, scope and strategic direction. The service has a business plan for 2020–2021. There is a documented quality and risk management programme that includes analysis of data. There are policies and procedures to provide appropriate support and care to residents at rest home and at dementia level care. An internal audit schedule is in place with audits completed as per schedule. There are human resources policies including recruitment, selection, orientation and staff training and development. The service has in place an orientation programme that provides new staff with relevant information for safe work practice. An annual education schedule is

being implemented and includes all required topics. A roster provides sufficient and appropriate coverage for the effective delivery of care and support and can be adjusted to support acuity level.

Continuum of service delivery

The service has assessment processes and residents' needs are assessed prior to entry. There is an admission pack available for residents and families/whānau at entry. Assessments, residents care plans and evaluations were completed by the registered nurses within the required timeframes. Risk assessment tools and monitoring forms were available and implemented. Resident care plans were individualised and included allied health professional involvement in care. The diversional therapist implements the activity programme to meet the individual needs, preferences and abilities of the residents. Community links are maintained. There are a variety of activities that are meaningful to the residents. There are medication management policies in place that meet the legislative requirements. Staff responsible for administration of medications complete annual medication competencies and education. Medication charts have photo identification and allergy status noted. Medication charts are reviewed three-monthly by a general practitioner. All food and baking is done on site. Resident's individual dietary needs were identified and accommodated. Staff have attended food safety and hygiene training.

Safe and appropriate environment

There is an emergency management plan to guide staff in managing emergencies and disasters. Six monthly fire drills occur. Civil defence supplies are in place. There were documented processes for the management of waste and hazardous substances in place, and incidents are reported in a timely manner. Chemicals were stored safely throughout the facility. The building has a current building warrant of fitness. Resident rooms and bathrooms are spacious. There is plenty of natural light in all rooms and the environment is comfortable with adequate ventilation and heating. Communal areas within the facility are easily accessible. The outdoor areas are safe and easily accessible and provide seating and shade. There is one person on duty at all times with a current first aid certificate. Housekeeping/laundry staff maintain a clean and tidy environment. Documented policies and procedures for the cleaning and laundry services are implemented with monitoring systems in place to evaluate the effectiveness of these services. The laundry is done on site.

Restraint minimisation and safe practice

Restraint minimisation and safe practice policies and procedures are in place to guide staff in the use of an approved enabler and/or restraint. Policy is aimed at using restraint only as a last resort. At the time of the audit there were no residents using restraint or enablers. Staff receive regular education and training around management of challenging behaviour.

Infection prevention and control

The infection control programme, its content and detail is appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a range of policies and guidelines. Surveillance data is collected, collated and used to determine infection control activities, education and resources within the facility. The infection control programme included audits of the facility, hand hygiene and surveillance of infection control events.

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	40	0	2	3	0	0
Criteria	0	87	0	2	4	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

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>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and relevant legislation. An information pack is available to residents/families prior to admission and contains information of their rights. Discussions with six care staff, including four caregivers and two registered nurses (RN) confirmed their familiarity with the Code.</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>The service has in place a policy for informed consent and resuscitation and is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There were signed general consents in all five resident files reviewed. Resuscitation treatment plans and advance directives were appropriately signed in the files reviewed. Discussions with caregivers and RNs confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. Discussion with relatives confirmed that the service actively involves</p>

		them in decisions that affect their relative's lives. Dementia files reviewed included activated EPOAs.
<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	Contact numbers for advocacy services are included in the resident information folder and in advocacy pamphlets that are available around the facility. Discussions with residents identified that the service provides opportunities for the family/EPOA to be involved in decisions.
<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	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. Activities programmes included opportunities to attend events outside of the facility including activities of daily living, (eg, shopping). Residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care.
<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	The service has a complaints policy and procedures in place and residents and their family/whānau are provided with information on admission. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. Since the last audit, the service has received one complaint in 2020 and one complaint in 2021 year to date. Appropriate actions have been taken in the management and processing of these two complaints reviewed. A complaints procedure is provided to residents within the information pack at entry. Residents and family members advised that they are aware of the complaints procedure and how to access complaint forms.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	There is an information pack available that includes information about the Code and the nationwide advocacy service. Residents and relatives have the opportunity to discuss aspects of the Code during

		<p>the admission process. Residents and relatives interviewed confirmed that information had been provided to them around the Code. Posters of the Code and advocacy information were displayed. A manager or RN discusses the information pack with residents/relatives on admission. Residents and relatives are informed of the scope of services and any liability for payment for items not included in the scope. This information is included in the service agreement. Five rest home residents and three family members (one rest home and two dementia level care) interviewed, confirmed the services being provided are in line with the Code.</p> <p>The interview with the prospective owners (husband and wife) confirmed that they own another rest home care facility and were able to describe the application of consumer rights.</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>	FA	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, residents' privacy and dignity. Residents are supported to attend church services held within the facility or attend church services in the community if they wish. Residents and relatives interviewed confirmed privacy and dignity was supported. Double rooms have curtains to ensure privacy and staff were observed knocking before entering rooms. Residents interviewed reported that they can choose to engage in activities and access community resources. There is an abuse and neglect policy, and staff receive education around this.</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>	FA	<p>The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. There were no residents that identified as Māori at the time of audit. Discussions with staff confirmed their understanding of the different cultural needs of residents and their whānau. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff have received training around cultural awareness.</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 values, and beliefs.</p>	<p>FA</p>	<p>Care planning and activity's goal setting includes consideration of spiritual, psychological and social needs. Residents interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs and are supported to maintain these.</p> <p>The interview with the prospective owners who own another rest home care facility confirmed that they could describe communication with residents who have different cultures.</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 job descriptions include responsibilities. The orientation programme provided to staff on induction includes an emphasis on dignity, privacy and boundaries. Staff meetings occur three-monthly and include discussions on professional boundaries and concerns as they arise. Interviews with the DT/assistant manager and caregivers confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home and dementia level care. The quality programme has been designed to monitor contractual and standards compliance and the quality-of-service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Combined quality/staff meetings are conducted every three months. Residents interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team. Caregivers' complete competencies relevant to their practice.</p> <p>They have opened a dementia unit in the past few months which staff stated is working well. Staff and relatives interviewed confirmed the smaller environment has suited the needs of the residents with dementia. Training has been provided to staff around caring for residents with dementia.</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>Relatives interviewed confirmed they are notified following a change of health status of their family member. This was confirmed in twelve incident forms reviewed. Residents also stated they were welcomed on entry and were given time and explanation about services and procedures. Resident meetings occur bi-monthly, and management have an open-door policy. The residents stated that management are on site daily and visit residents to ask about their wellbeing. The service has policies and procedures available for access to interpreter services for residents (and their family). If residents or family/whānau have difficulty with written or spoken English, the interpreter services are made available.</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>	<p>FA</p>	<p>Westmar Senior Care (Ltd) can provide care for up to 28 residents (21-bed rest home including three double rooms and 7-bed dementia care unit). On the day of the audit there were 24 residents in total. This includes 17 residents in the rest home and 7 residents in the secure dementia unit. There was one rest home resident on a younger person's disability (YPD) contract and all other residents were under the Aged Residential Care (ARC) contract.</p> <p>The proprietors have owned/managed Westmar Senior Care for five years. The owner/manager is supported by a DT/assistant manager in the responsibility of the daily operations, finance, maintenance, and overseeing the delivery of services. The management team are also supported by two RNs who job share and provide cover for each other (30 hours a week).</p> <p>The service has a business plan for 2020-2021. The mission statement sets out the vision and values of the service and is displayed at the entrance to the facility and in the information pack. This is given to each resident and family on admission.</p> <p>The owner/manager and DT/assistant manager have attended at least eight hours of training relating to managing a rest home including attendance at aged care provider and regular local hospital meetings.</p> <p>The prospective provider owns another rest home care facility in Christchurch. One of the prospective owners (who is a registered</p>

		<p>nurse and experience with residents with dementia) will be taking over the owner/manager's role. She will be supported in this role by the current DT/assistant manager.</p> <p>The prospective owners are experienced directors/managers and have managed another rest home care facility for five and a half years. There is a transition plan to ensure a smooth transition during the change of ownership. The intended settlement date is 1 May 2021.</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>During the temporary absence of the owner/manager, the DT/assistant manager will fill the role with support from the RNs. This will continue with change of ownership.</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>	FA	<p>The owner/manager and DT/assistant manager jointly facilitate the quality programme and ensures the internal audit schedules are followed. Corrective action plans are developed and signed off when service shortfalls are identified. Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. Quality data is collated for accident/incidents, infection control, internal audits, concerns and complaints, and surveys. Quality improvement data is distributed in a monthly statistics memo and discussed at three-monthly combined quality/staff meetings. Resident meetings have been held regularly every two months.</p> <p>There are policies and procedures relevant to the service types offered and these are reviewed and updated at least two-yearly. There is a current risk management plan. Hazards are identified, managed and documented on the hazard register, which was last reviewed on 10 January 2021. The health and safety officer (DT/assistant manager) has completed stage three health and safety training. Health and safety issues are discussed at three-monthly quality/staff meetings with action plans documented to address issues raised. There are resident/relative surveys conducted and analysed annually. The August 2020 resident and family surveys evidenced that residents and</p>

		<p>families are overall satisfied with the service being provided. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls.</p> <p>The prospective owners stated that their governance and quality management system, and policies and procedures will be reviewed with an independent quality management systems provider (approximately three to six months), until then the current policies/procedures will stay in place.</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>	<p>PA Moderate</p>	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twelve incidents reviewed from February, January 2021 and December; November 2020 demonstrated clinical follow-up. However, not all neurological observations were completed for resident falls with a potential head injury. Accidents and incidents are analysed monthly with results shared at the monthly toolbox meetings and in a memo signed by all staff and is also discussed at the three-monthly combined quality/staff meetings. The managers are aware of situations that require statutory reporting. There have been no section 31 notifications completed since the last audit. A respiratory outbreak in May 2020 was notified to public health authorities.</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>There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files reviewed (one DT/assistant manager, one RN, three caregivers and one chef/cook) showed appropriate employment practices and documentation. All staff files reviewed for staff who have been employed for more than 12 months contained a current annual performance appraisal. The recruitment and staff selection process requires that relevant checks are completed to validate the individual's qualifications, experience and suitability for the role. Current annual practising certificates are kept on file. The orientation package provides information and skills around working with residents with rest</p>

		<p>home and dementia level care.</p> <p>There is an annual training plan in place for 2021. The service has implemented an online training programme and through this channel increased in-service training with staff over the past six months. Toolbox talks, and meetings are completed monthly. Four of eight caregivers working in the dementia unit have completed the required dementia standards and the other four are in progress of completing. The DT/assistant manager is a trained diversional therapist (DT) who has also completed the Spark of Life training. There are two RNs, and both have completed interRAI training. Staff receive first aid training, however two of three staff who drive the facilities van for resident outings did not have a current first aid certificate (link 1.4.7.1).</p>
<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>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The DT/assistant manager is on call after hours for all non-clinical issues and the RNs are on call for any clinical issues. The local general practitioner (GP) also provides after hours care if required and caregivers have access to the 0800 rural emergency after hours paramedic. There is an RN on site on the morning shift from 8 am to 2.30 pm weekdays.</p> <p>In the rest home (21 beds and 17 residents): there are two caregivers (one med comp) on the morning shift, two caregivers (one med comp) on the afternoon shift and one on the night shift. There is a housekeeper daily who also completes laundry for three hours in the morning.</p> <p>In the dementia unit (seven beds and seven residents): there is one caregiver on the morning shift; one caregiver on the afternoon shift and one on the night shift. The housekeeper completes laundry for one hour in the morning. The DT/assistant manager oversees the activities in the dementia unit that are being implemented by the caregivers. All caregivers have completed training around the activity programme.</p> <p>Staff from the rest home will relieve the caregiver in the dementia unit</p>

		<p>for a break where needed. All call bells have 'call assist' as well, so another caregiver can be called to help where needed in the dementia unit.</p> <p>The interview with the prospective provider confirmed that there will be no proposed changes to the existing staff apart from one of the prospective owners taking over the owner/manager's role.</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 service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Individual resident files demonstrated service integration. Entries are legible, dated and signed by the relevant staff member including designation.</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>Residents' entry into the service is facilitated in a competent, equitable, timely and respectful manner. Residents are assessed prior to entry to the service by the needs assessment (NASC) team, and an initial assessment with an interRAI assessment completed on admission. Admission information packs on the services and levels of care are provided for families and residents prior to admission or on entry to the service. There is specific information provided for families regarding dementia care.</p> <p>In the dementia unit two resident files were sampled and had NASC approval for the service and EPOA activation letters on file. All admission agreements reviewed aligned with all contractual requirements. Exclusions from the service are included in the admission agreement. A total of five signed admission agreements were sighted. Family members interviewed confirmed the staff had fully explained services to them on entry to the service.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The transfer/discharge/exit procedures include a transfer/discharge form, and the completed form is placed on file. The service stated that</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>a staff member escorts the resident if no family were available to assist with transfer, and copies of documentation are forwarded with the resident. Hospital discharge documentation is integrated in the resident file and care plan.</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>PA Moderate</p>	<p>The medication management system includes a medication policy and procedures that follows recognised standards and guidelines for safe medicine management. Shortfalls were identified in the management of the controlled drug register and process of reconciliation of controlled drug stock. All medicines are stored securely. Registered nurses and caregivers' complete annual medication competencies and medication education. The medication room is in the rest home near the nurse's station. RNs or a caregiver complete the administration of medication in the rest home and will continue with the medication trolley into the dementia unit. Medication management internal audit (100%) was last completed in August 2020; there were no medication errors/incidents.</p> <p>The RN is responsible for medication reconciliation against the blister packs for regular and 'as required' medications. Any discrepancies are fed back to the supplying pharmacy who are available after hours if required. The medication fridge temperature and medication room temperature are being monitored daily and both were within acceptable limits. There are procedures in place to facilitate safe self-administration of medication for six rest home residents. There are no medication standing orders in use. There is a local GP practice that provides medical services to the residents at Westmar Senior Care and review the medication charts once in three months.</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>All meals at Westmar Senior Care are prepared and cooked on site. The kitchen is based in the rest home with a servery opening out to the rest home dining area. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Dietary needs are known with individual likes and dislikes accommodated. All food preferences are met. Fridge and freezer temperatures are taken and recorded daily. End cooked food temperatures and food temperatures prior to the food</p>

		<p>being served to the residents are recorded. A current food control plan is in place expiring 25 July 2021. There are four cooks and four kitchenhands, and all have completed food safety education. Residents' nutritional assessment including likes and dislikes are identified and provided to the kitchen on admission. The kitchen manager interviewed is knowledgeable regarding specific residents needs including those with diabetes, unintentional weight loss and recent dietitian input.</p> <p>Meals are plated in the kitchen and delivered on covered trays to the dining area of the dementia wing. Meals are plated and directly served from the kitchen to the dining room in the rest home. The kitchenette in the dementia wing has storage for cutlery and a fridge for storage of fruit and other food items. On the day of the audit three staff were observed to assist with the meals in the dementia unit and both dining rooms have enough space to move safely during mealtimes. Snacks are available 24/7 and special cutlery is available when needed. A food service internal audit was last completed 1 August 2020. No corrective actions were required. The resident/family annual survey was completed in August 2020 and general satisfaction was expressed with the food service. Residents and families interviewed expressed satisfaction with the meals provided at Westmar Senior Care.</p> <p>There is an established system in place, the prospective owners do not have any environmental changes planned for the kitchen and meal service.</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>	FA	<p>The service records the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurs. Potential residents are then referred back to the referring agency.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>The RN completes an initial assessment on admission including risk assessment tools as appropriate. An interRAI assessment is undertaken within 21 days of admission and every six months. One resident had an earlier interRAI assessment completed due to recent</p>

		<p>health changes and prior transfer to the dementia unit. Resident needs, support and goals are identified through the ongoing assessment process and form the basis of the long-term care plan. There were regular pain assessments evident for a resident with complex co-morbidities. Residents interviewed confirmed their preferences and choice are accommodated during their care journey.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>PA Moderate</p>	<p>Five residents' long-term care plans were reviewed. The interRAI assessment triggers and scores forms the basis of the long-term care plan. Three files (one in the dementia wing and two rest home) residents care interventions were not detailed to a level that supports their individual needs and goals. Assessment outcomes were included in the long-term care plans reviewed. The long-term care plan identifies interventions that cover a set of goals including managing medical needs/risks.</p> <p>Alerts on the resident's profile page identify current and acute needs such as (but not limited to); current infection, wound or falls risk. Short-term needs are added to the long-term care plan. Care plans evidenced resident (as appropriate) and family/whānau involvement in the care plan process. Relatives interviewed confirmed they were involved in the care planning process. Resident files demonstrated service integration.</p> <p>The two residents in the dementia wing files included a 24-hour activity plan and recreational plan with documented individual daily routine, behaviours, triggers and activities to distract and de-escalate behaviours. The long-term care included specific medical risks and detailed behaviour management plan. There was evidence of allied health care professionals involved in the care of residents including physiotherapist, podiatrist, dietitian and a dental nurse. Two residents in the rest home had a specific plan for unintentional weight loss. Residents in the dementia wing have detailed behaviour plans to monitor behaviour and associated risks. The contracted physiotherapist reviews residents for mobility support and mobile scooter competencies. The GP, dietitian and allied health professional progress notes were evident in the resident's files sampled. Any change in care required is documented and verbally passed on to</p>

		relevant staff.
<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>Documentation, observation and interview with the RNs verified that care provided to the residents in the rest home and newly added dementia wing was consistent with their needs, goals and plan of care (link 1.3.5.2). The interview with the GP confirmed that discussion and referral to allied health professionals took place in a timely manner. When medical input was required, notification occurred promptly, and any medical orders were appropriately carried out. Family/whānau expressed during interview that assistance was given according to the wishes of their relatives. Specialised equipment including sensor mats, transfer belts, pressure relieving mattresses and cushions were available for use. Continence and wound care products were in stock for use. Staff received education in continence management in January 2021.</p> <p>The wound register was reviewed and current; an updated wound care policy including PI management, and management of skin, nutrition and hydration needs were reviewed. Wound assessment and wound management plans were in place for three residents (across services). There were no residents with current or recent pressure injuries, two minor skin tears and one surgical wound were recorded in the wound register. Wound assessments, plans and reviews are current and completed. Interventions were undertaken in the stated timeframes. Registered nurses interviewed were aware of when and how to get specialist wound advice when needed. Monitoring records for (but not limited to) weight, food and fluids, blood sugars, behaviours and routine observations including neurological observations after unwitnessed falls demonstrated that appropriate cares are occurring (link 1.2.4.3).</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>	FA	<p>The DT/assistant manager is employed for 40 hours a week and has been in the role for 13 years, she also acts as acting manager in the absence of the owner/manager until 1 May 2021. The DT/assistant manager is supported by three caregivers (one for the dementia wing and two for the rest home) to assist with activities during the week</p>

		<p>whilst doing the dual DT role. There are regular volunteers who assist with delivery of activities across seven days a week. A resident profile is completed soon after admission. Each resident has an individual activity plan developed within three weeks, which is reviewed at least six-monthly.</p> <p>A monthly planner is developed by the activities team to include resident favourites such as housie, newspaper reading, word games, crafts, quizzes, exercises, manicures and daily walks (weather permitting). Church services are held each Sunday, and communion is held for residents. The activities are provided from 8.30 am to 3 pm. Volunteers in the dementia wing will assist with activities between 3 pm and 5.30 pm. Visitors often visit at this time. Activities are provided by caregivers and volunteers over the weekends. A DT cupboard has been set up in the dementia unit to support caregivers completing activities with the residents. The DT/assistant manager has trained caregivers around providing activities with residents.</p> <p>The residents in the dementia wing have a 24-hour diversional plan to assist the caregivers in the individual's daily routine, specific behaviours, triggers and de-escalating activities. On the day of the audit several residents were accompanied by caregivers (including dementia wing) for a walk outside the facility. Being situated in a small community, close links with the community is ongoing and residents are supported to attend Probus and Darfield Senior Citizen club. There are weekly outings available, and the activities team accommodate residents' interests. The service receives feedback on activities through one-on-one feedback, residents' meetings and annual surveys. Quality of life/DT internal audit is completed annually and last completed 4 March 2020 with no corrective actions required.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>The initial care plan is evaluated in consultation with the resident/relative and long-term care plans developed. Long-term care plans reviewed had been evaluated six monthly or earlier for any changes to health. The resident/relative are invited to attend the multidisciplinary review with a manager, RN, caregiver and DT. There is a written evaluation against the resident goals that identifies progression towards meeting goals. Long-term care plans are</p>

		updated with any changes to meet the resident goals. Short-term care plans were evident for the care and treatment of short-term problems for residents, and these had been evaluated, closed or transferred to the long-term care plan if the problem was ongoing.
<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>	FA	Westmar Senior Care facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The RNs initiate referrals to nurse allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family, as evidenced in medical notes. There was evidence of referrals to the dietitian, dental services, physiotherapy and the podiatrist.
<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>	PA Low	<p>There are implemented policies in place to guide staff in waste management. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly in the original containers, and safety data sheets and product information are readily available to staff. Gloves, aprons and visors are available, and staff were observed wearing personal protective clothing while carrying out their duties. RNs and caregivers interviewed confirmed enough pandemic supplies are available. Staff have completed chemical safety training. There are implemented policies in place to guide staff in waste management.</p> <p>Two hand sanitiser dispensers are available in the shower/toilet areas of the dementia wing however, this cannot be accessed by staff or visitors when these areas are occupied.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	The facility has a building warrant of fitness that expires 1 July 2021. The owner/manager is responsible for maintenance and has overall responsibility for building compliance. A maintenance folder is maintained, including a record for preventative and reactive maintenance electrical testing and tagging, calibration of clinical equipment, and monthly hot water temperatures. Hot water

		<p>temperatures in resident areas are maintained below 45 degrees. Essential contractors are available 24-hours. There are sufficient supplies of equipment including (but not limited to); wheelchairs, oxygen concentrators, sensor mats, chair sensor mats, pressure relieving mattresses and equipment for clinical assessments such as thermometers and sphygmomanometers. The physical environment in both areas allows easy access/movement for the residents. The hallways have handrails to support residents. Cameras are available in the blind spot of the hallway.</p> <p>The physical environment allows easy access/movement for the residents and promotes independence for residents with mobility aids. The door between the communal lounge in the rest home and the dining room in the dementia unit is secure. The furniture in each wing is appropriate for the number of residents. Previous doors were removed to open up the area. There is a ramp to the front door of the facility. Outdoor areas have a maintained garden and patio areas with safe access. Residents from the dementia wing can access a secure enclosed garden area. The garden area has a raised fence and a safe walkway. There is outdoor seating and shade provided. There is a secure cupboard for resident records in each wing. RNs interviewed confirmed private conversations are directed to the nurse's station, resident rooms or administration office. A resource consent has been obtained for phase two extension (additional 8 rooms).</p> <p>The prospective owners do not have immediate plans for any structural changes to the facility.</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>Resident rooms have handwashing facilities. There are sufficient communal toilet/showers to meet the needs of the residents. All communal toilets and showers have appropriate signage and locks on the doors. Fittings, fixtures and flooring is appropriate. Communal staff and visitor toilets are identifiable and equipped with locks, flowing soap and paper towels. All rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Six rooms have a handbasin and the seventh room is situated next to one of the communal bathrooms. Residents' rooms are personalised. There are an adequate number of toilet and showering</p>

		facilities. Privacy locks are in place. Vacant/in use signage is on the toilet/shower rooms. All residents interviewed confirmed their privacy was maintained while attending to personal hygiene cares.
<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>	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. There are three double rooms in the rest home which at present have single occupancy. Residents are encouraged to personalise their bedrooms.
<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>	FA	In the dementia unit, there is a combined dining and lounge area to meet the dining and seating for relaxation requirements. The dining room adjacent to the kitchen area provides adequate space for rest home residents to enjoy their meals. There is a large lounge used for activities and a separate lounge area adjacent for residents who choose not to participate in activities to enjoy. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the resident group. Residents were seen to be moving freely within the communal areas throughout the audit. Residents interviewed reported they can move freely around the facility and staff assist them if required. Activities occur at the tables or in the small lounge area in the dementia wing. The dementia residents can be taken through to the rest home lounge for some communal activities such as entertainers.
<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>	FA	There is a designated cleaner who completes the cleaning and laundry service. The cleaning trolley is well equipped, and all chemicals are labelled. All chemicals are securely stored. Protective wear including plastic aprons, gloves, masks and goggles are available in the laundry. Staff observed on the day of audit were wearing correct protective clothing when carrying out their duties. The laundry has a clean/dirty flow. Internal audits monitor the effectiveness of the laundry service. Residents expressed satisfaction with cleaning and laundry services.

<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>PA Low</p>	<p>There is an emergency management plan to guide staff in managing emergencies and disasters. The facility has an updated and approved fire evacuation scheme letter, dated 12 January 2021. Fire evacuation drills are completed every six months (last occurred on 17 February 2021). The service has also implemented a McHugh's forest fire evacuation plan in regard to a potential hazard and identified fire risk to Darfield and Westmar Senior Care if McHugh's forest were to catch on fire. A contracted service provides checking of all facility equipment including fire equipment. Civil defence supplies are checked six-monthly. The facility has back-up lighting for up to four hours, a generator for power and sufficient food and personal supplies to provide for its maximum number of residents in the event of a power outage.</p> <p>There are alternative cooking facilities available with a gas barbeque and gas cooker. There is a water tank (1,000 litres) that ensures sufficient water supply. The staff are responsible for checking the facility for security purposes on the afternoon and night shifts. There are secure doors from the rest home to the dementia unit and at the entrance to the communal areas. The external garden area in the dementia unit is secure. Call bells in the dementia unit include a 'call assist' button and can be heard in the rest home. Staff also have walkie talkies available. There is a list of staff and community numbers for emergency contact. The nurse call system is appropriate for the size of the facility and call bells are accessible in the rooms and communal lounge area. There is a staff member on each shift with a current first aid certificate.</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>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. Panel heaters, ceiling heating and a heat pumps are in place. All resident rooms and the communal area have external windows that open, allowing plenty of natural sunlight.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>Westmar Senior Care has an established infection control programme. The infection programme is appropriate for the size, complexity and</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>degree of risk associated with the service. An RN is the designated infection control person with support from all staff. Infection control matters are routinely discussed at all quality/staff meetings. Education has been provided for staff. The infection control programme has been reviewed annually.</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>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme. Both RNs share the responsibility of infection prevention and control. The infection control team includes all staff through the quality/staff meeting. External resources and support are available when required. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is available (link 1.4.1.1). All Covid-19 resources are integrated in the infection control/pandemic plan.</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>	<p>FA</p>	<p>The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two-yearly.</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>	<p>FA</p>	<p>The staff orientation programme includes infection control education. The infection control person has completed infection control updates and provides staff in-service education. Frequent toolbox meetings occurred during Covid-19 for correct use of PPE and handwashing. Education is provided to residents during daily support. Residents interviewed are aware of the Covid-19 requirements to minimise own risk. Residents are informed in a timely manner of expectations and at monthly resident meetings of all appropriate infection prevention requirements.</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>	<p>FA</p>	<p>Infection surveillance is an integral part of the infection control programme and is described in the infection control manual. Monthly infection data is collected for all infections, based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and compared month by month. Outcomes and actions are discussed at quality/staff meetings and results published for staff to view. If there is an emergent issue, it is acted upon in a timely manner. The RN prepares graphs and reports based on information collated during the month. A respiratory outbreak in May 2020 was managed appropriately and notification to public health was completed (link 1.2.4.3).</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. The service philosophy includes that restraint is only used as a last resort. At the time of the audit there were no residents using restraint or enablers. Staff receive regular education and training around management of challenging behaviour.</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)
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	<p>PA Moderate</p>	<p>The accident/incident process includes documentation of the incident and analysis and separation of resident and staff incidents and accidents. Twelve incidents reviewed from February, January 2021 and December; November 2020 demonstrated clinical follow-up. However not all neurological observations were completed as directed by policy for resident falls with a potential head injury.</p>	<p>Twelve incident forms were reviewed in total. Six incident forms were reviewed for resident falls with a head injury. Five of six neurological observations forms were not completed as per policy.</p>	<p>Ensure that neurological observations are fully completed for any resident with a potential head injury.</p> <p>60 days</p>
<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and</p>	<p>PA Moderate</p>	<p>Ten medication charts and the controlled drug register were reviewed. The medication charts reviewed met legislative requirements. Appropriate practice was demonstrated on the witnessed medication round. Controlled drugs are kept in a controlled drug cabinet in a</p>	<p>The following shortfalls were identified:</p> <p>i) One administration entry in the controlled drug register has only one signature against the entry.</p>	<p>Ensure all aspects of controlled drug management complies with own policy and medication guidelines.</p>

<p>medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>		<p>locked room and accessible to authorised staff only. Controlled drug transactions are documented in a controlled drug register by two staff. The keys to controlled drugs are held by a senior authorised staff member on each duty. A list is available of the staff authorised and competent to manage the medication process. Two rest home residents who require controlled drugs are stable and do not require frequent clinical assessment by a RN.</p>	<p>ii) Five weekly stock count entries were signed by only one person: and iii) The signature list of evidence of medication competent staff is incomplete.</p>	<p>60 days</p>
<p>Criterion 1.3.12.3 Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>	<p>PA Moderate</p>	<p>The RNs and caregivers who are responsible for medication administration complete an annual medication competency. Two medication competent staff are on duty to witness controlled drug administration. This is recorded on the electronic management system (1Chart) and in the controlled drug register. Weekly stock count and six-monthly stock counts is completed by the RNs. The medication management policy for controlled drugs refers to a 'second checker competency' required for staff when signing against weekly stock count and six-monthly stocktake.</p>	<p>The DT/assistant manager regularly signs as a second checker in the controlled drug register against weekly stock count however do not hold a 'second checker competency' assessment as required by the policy.</p>	<p>Ensure staff who are responsible as 'second checker' during the stock count process are competent to perform the function. 60 days</p>
<p>Criterion 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment</p>	<p>PA Moderate</p>	<p>Five long-term care plans were reviewed. A variety of assessment tools formed the basis of the long-term care plan with individual goals and expected outcomes. Caregivers and RNs interviewed confirmed they have knowledge of all</p>	<p>The following shortfalls were identified in the files reviewed: The care plan interventions did not provide sufficient detail to guide staff to support and manage an expected</p>	<p>Ensure interventions documented promote the individual's expected outcome and to a level required that sufficiently guide staff in the</p>

process.		residents' needs. Three of five long-term care plans did not reflect the detailed interventions required to support all identified medical risks or expected outcome. Short term needs, and allied health instructions were integrated into the care plans. The family members and residents interviewed reported that they were satisfied with the care provided and the communication they received.	outcome for: i) one resident in the dementia wing with frequent falls ii) one rest home resident with diabetes management specific to the BSL parameters and iii) one rest home resident with pain, breathlessness and fatigue due to COPD.	management of their care. 90 days
Criterion 1.4.1.1 Service providers follow a documented process for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements.	PA Low	Chemicals sighted were labelled correctly in the original containers and stored securely. There are plenty of portable hand sanitisers in the rest home for staff and visitors to meet the increased need for hand sanitising requirements during the Covid-19 pandemic period. In the dementia wing hand sanitiser dispensers are placed in the toilet/shower areas. The provisional audit occurred during Covid-19 alert level two. Safe PPE donning/doffing areas have been identified as part of pandemic planning. There is a sluice within the laundry in the rest home. Buckets are available to transport any soiled clothing from the dementia unit to the sluice.	Two hand sanitiser dispensers are available in the shower/toilet areas of the dementia wing however, this cannot be accessed by staff or visitors when these areas are occupied.	Ensure adequate numbers of hand sanitisers are available in the dementia wing to help meet the increased demand for safe and effective hand sanitising during the Covid-19 pandemic period and to minimise risk. 90 days
Criterion 1.4.7.1 Service providers receive appropriate information,	PA Low	Fire evacuation drills are completed every six months (last occurred on 17 February 2021). Staff receive first aid training, however two of three staff who drive the	Two of three staff who drive the facilities van for resident outings did not have a current	Ensure that all staff who drive the facilities van for resident outings have a

<p>training, and equipment to respond to identified emergency and security situations. This shall include fire safety and emergency procedures.</p>		<p>facilities van for resident outings did not have a current first aid certificate</p>	<p>first aid certificate.</p>	<p>current first aid certificate. 90 days</p>
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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.