

# Sandra MacLean - Lady Elizabeth Home and 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:

<b>Legal entity:</b>	Sandra MacLean
<b>Premises audited:</b>	Lady Elizabeth Home and Hospital
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 21 June 2021    End date: 22 June 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>	52

# 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
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Lady Elizabeth Home and Hospital provides rest home and hospital level of care for up to 55 residents. The service is operated by a registered nurse manager who is the owner of the facility. The registered nurse manager is supported by an assistant manager, personal secretary, kitchen manager, activities coordinator and a team of registered nurses.

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

There were no areas identified for improvement from this audit. A continuous improvement rating has been made in relation to staff education for service providers.

## Consumer rights

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

The implemented systems and the environment are conducive to effective communication. There is access to interpreting services if required. Staff provide residents and family/whānau with the information they need to make informed choices and give consent.

There is a Maori health plan to guide staff to ensure that residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect, or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet residents’ needs.

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

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Standards applicable to this service fully attained.
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Business and quality and risk plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services is provided by the registered nurse manager who works full time at the facility. The registered nurse manager holds a valid annual practising certificate and has owned and operated Lady Elizabeth Home and Hospital for over thirty years. All staff holding senior roles are suitably qualified and experienced for the roles they undertake.

The quality and risk management system includes collection and analysis of quality improvement data, any trends are identified and resulting actions lead to quality improvements. Feedback is sought from staff, 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 as needed and were up-to-date.

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

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

## Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Entry processes are efficiently managed by the registered nurse manager, administrator/secretary and registered nurses. The registered nurses and the general practitioner (GP) assess residents on admission. The care plans demonstrated appropriate interventions and are individualised. Residents are reviewed regularly and referred to specialist services and to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

## Safe and appropriate environment

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

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. 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. Fire evacuation procedures are regularly practised. Residents reported a timely response to call bells. Security is maintained.

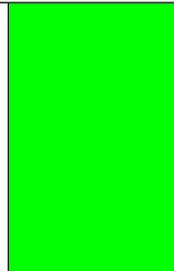
## Restraint minimisation and safe practice

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.
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The organisation has implemented policies and procedures that support minimisation of restraint. No enablers were in use at the time of the audit and no restraints. Use of enablers is voluntary for the safety of residents in response to individual requests. The restraint team meet six monthly to review any use of both enablers and restraints. Policy identified that assessment, approval and monitoring processes meet the restraint standard requirements. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme is overseen by a trained infection control coordinator and aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, and results shared with all staff. Follow-up action is taken as and when required.

## 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	45	0	0	0	0	0
<b>Criteria</b>	1	92	0	0	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>Lady Elizabeth Home and Hospital has developed policies, procedures, and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). The staff were observed communicating with residents in a respectful manner. The residents confirmed they were encouraged to be independent, options were provided, and privacy and dignity were maintained. The interviewed staff understood the requirements of the Code and training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records sighted.</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 interviewed RN manager, RNs and caregivers understood the principles and practice of informed consent. Informed consent policies provided relevant guidance to staff. Informed consent is part of the admission agreement and has been gained appropriately. Signed admission agreements were sighted in the clinical files reviewed. Resuscitation treatment plans and advance directives are also part of the admission agreement and were sighted in the reviewed residents' records.</p> <p>Staff were observed to gain consent for daily cares. The interviewed residents confirmed having signed the admission agreements and consent forms as required. Influenza vaccination consent forms were sighted, as were COVID-19 vaccination consent forms.</p>

<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>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were displayed and available at the reception area. The interviewed family/whānau and residents were aware of the Advocacy Service, how to access this and their right to have support persons.</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>The service encourages visits from residents' family/whānau and friends. A number of visitors were observed visiting residents on the days of the audit. There are no restrictions to visiting hours. The required visiting restrictions were implemented during the level two to four COVID- 19 pandemic infection prevention and control and measures as per MOH guidelines.</p> <p>Family/whānau interviewed stated they felt welcome when they visited and comfortable in their dealings with staff. Residents are assisted to maintain links with their family and the community by having organised external entertainers visiting the facility, and residents can go out on social outings with family.</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. Complaints forms are available at the entrance to the Lady Elizabeth Home and Hospital. Complaints and compliments can also be placed in a locked complaints box at reception.</p> <p>The complaints register reviewed showed that no complaints had been received over the past year. A previous complaint followed through demonstrated that actions were taken through to an agreed resolution, were documented and completed within the required timeframes. Any quality improvements are made where possible. The registered nurse manager (RNM) 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>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Residents and family/whānau interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and from discussions with staff on admission. The Code, in English and te reo Maori languages, was displayed at the reception together with information on advocacy services, complaints, and feedback forms and in various areas around the facility. There is a complaints and suggestion box at the reception area that is accessible to residents and family/whānau.</p>

<p><b>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</b></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>All residents have a private room that provides visual, auditory, and personal privacy to residents. Residents and family/whānau confirmed that services are provided in a manner that has regard for their dignity, privacy, sexuality, spirituality, and choices. Residents are allowed to bring limited personal furniture items, for example, a desired chair as appropriate. The personal belongings and property are recorded on admission and are labelled for easy identification. The residents reported that they receive back their clothes after laundering in a timely manner. Personal cares were provided behind closed doors during the audit days. There are bathrooms with clear signage when in use.</p> <p>Residents are supported to attend to community activities and to maintain their independence. The care plans included documentation related to the residents' abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious, and social needs, values and beliefs had been identified, documented, and incorporated into their care plan.</p> <p>Interviewed staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually. The interviewed GP, residents and family/whānau have not witnessed or observed any abuse nor neglect.</p>
<p><b>Standard 1.1.4: Recognition Of Māori Values And Beliefs</b></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>Residents who identify as Māori are supported to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into daily practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available. Maori cultural advisory is provided through the local DHB if required. Residents who identify as Māori and their whānau reported that staff acknowledged and respected their individual cultural needs. Staff have received education on cultural awareness.</p>
<p><b>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</b></p> <p>Consumers receive culturally safe services which recognise and respect their</p>	<p>FA</p>	<p>Residents' individual culture, values and beliefs were identified during the admission assessment. Residents or residents' representative of choice or enduring power of attorney (EPOA), where appropriate, provided this information during the admission process. Interviewed residents and family/whānau confirmed that they were consulted on individual values and beliefs and staff respected these. Residents' individual preferences, required interventions and special needs were included in the care plans reviewed. The resident/relative satisfaction survey confirmed that individual needs are being met.</p>

ethnic, cultural, spiritual 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>Residents, family/whānau and the GP stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. These are included in the employee handbook and are discussed with all staff during orientation period. The registered nurses have completed training on professional boundaries. 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.</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 evidence-based policies, internal audits, input from external specialist services and allied health professionals, for example, a wound care specialist, mental health services for older persons, and education of staff. The annual education planner included mandatory training topics. The GP confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>The RNs have access to external education through the local hospital, though this has been limited over the past year due to COVID-19 pandemic restrictions. Staff reported that they receive support from senior staff as required.</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>Residents and family/whānau stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. The GP confirmed that meetings with family/whānau are arranged by the RN manager or registered nurses (RNs) if requested or when required. This was evident in residents' records reviewed. Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code.</p> <p>The RN manager reported that access to interpreter services is through the local district hospital board. Staff knew how to access interpreter services, although reported this was rarely required due to most residents able to speak English. Staff can provide interpretation as and when needed, or family/EPOA are used for those with communication difficulties.</p>
Standard 1.2.1: Governance	FA	<p>The strategic, quality and business plans, which are reviewed annually, outline the purpose, values, scope direction and goals of the organisation for 2021 and 2022. Five goals are set and these are reviewed</p>

<p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>		<p>regularly for progress and achievement. A sample of monthly and quarterly reports to governance includes the monitoring performance outcomes, including quality data results, staffing, complaints, quality improvements made, any emerging risks and issues.</p> <p>The service is managed by a registered nurse manager (RNM) with a current annual practising certificate and relevant qualifications in nursing and management. The RNM has been in the role for approximately 33 years. Responsibilities and accountabilities are defined in a job description. A team of registered nurses (RNs) support the RNM and an assistant manager, all of whom have individual employment agreements which were reviewed. The RNM and registered nurses confirmed their knowledge of the aged care sector and maintained currency through regular ongoing clinical education related to their individual roles. This was confirmed in education documentation sighted.</p> <p>The service holds contracts with Counties Manukau District Health Board (CMDHB) and the Ministry of Health (MoH) for younger persons under 65 years, respite, complex medical conditions, long term support chronic health conditions (LTSCHC), rest home and hospital level care, including palliative care. On the day of the audit there were 52 residents including 17 rest home level and 35 hospital level care residents receiving care. This included one under 65-year-old (LTSCHC) hospital level care resident. No residents were receiving respite care and/or primary options for acute care (POAC).</p> <p>There are six units located on the same site which are occupied by private renters (They are not ORA contracted).</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>When the RNM is absent, the personal assistant manager is able to carry out all the required duties. During absences of key clinical staff, the senior registered nurses, who are all experienced in the sector are able to take responsibility for any clinical issues that may arise. Staff reported the current arrangements work effectively. The RNM stated that in the event of the RNM being absent for an extended period of time the management team is to continue to perform the duties of the RNM. They would be supported and under supervision of professional advisors including the general practitioner, an accountant and the owner/RNM's solicitor. The personal assistant manager would be responsible for coordinating the team and reporting to the RNM on her return to duty.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented,</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 accidents, complaints, audit activities, an annual resident and food satisfaction survey (2021), monitoring of outcomes and clinical incidents including any infections, falls, skin tears, wounds, challenging behaviour and pressure injuries.</p>

<p>and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the weekly senior registered nurse meetings, monthly management meetings and quality/staff meetings. Residents' meetings are held monthly and feedback is sought on the food service and care services at every opportunity. Unique to this service is the multidisciplinary review meetings; the last one was held on the 25 May 2021 attended by the GP, pharmacist, RNM, physiotherapists and an RN. The GP has been involved with this service for 30 years. Any issues raised are discussed and dealt with at this meeting.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family members interviewed expressed positive views on the staff and services provided. The RNM stated that any concerns raised by residents or family/whanau are followed up using the corrective action process.</p> <p>Policies reviewed cover all necessary aspects of the service delivery and contractual requirements and are reviewed annually. The document control system to manage the policies and procedures is clearly documented. Any obsolete documents are removed from the system, stored appropriately and can be retrieved if needed.</p> <p>The RNM described the processes for the identification, monitoring and reporting of any risks and development of mitigation strategies. The staff management team are fully informed and familiar with the Health and Safety at Work Act (2015) and the requirements have been implemented. The service has a health and safety committee who actively maintain and review all known and newly identified hazards and risks. The hazard registers are maintained and were current for each area of service delivery. Residents and families interviewed were satisfied with all aspects of service delivery.</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>FA</p>	<p>Staff documented adverse and near miss events on an incident form. Incidents sampled were investigated, action plans developed and actions followed up in a timely manner. Adverse event data is collated, analysed and reported at the senior management team meeting and weekly registered nurses' meetings and at staff meetings. The RNM is informed daily of all incidents and accidents. Documentation identifies that family are notified and kept well informed in a timely manner.</p> <p>The RNM described essential notification reporting requirements, including for pressure injuries. They advised that there have been no section 31 notices completed and sent to HealthCERT. There was one notification to the DHB of a resident falling, being transferred to the DHB, sent back to this home, assessed by the physiotherapist, readmitted and did require surgery and was transferred back to the facility for rehabilitation. A full investigation was completed and all documentation was available. There have been no police investigations, coroner's requests, issues-based audits and any other notifications such as infection outbreaks, during this time.</p>

<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Human resource management policies, procedures and processes are based on good employment practice and required legislation. The recruitment policy, reviewed January 2021, and staff selection policy and process includes, police vetting checks from previous employers, referee checks and validation of qualifications and annual practising certificates (APCs) for all health professionals employed and/or contracted to the service. 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. The RNM interviews staff and the secretary ensures the staff records are filed and stored appropriately and confidentiality is maintained. The records showed that an annual performance review is undertaken annually for all staff.</p> <p>Staff training has been a strong element of the service. Many staff have been employed for 15 to 20 years. Staff interviewed stated they would not work anywhere else and that they have learnt something every day with the support of the RNM and other staff. The RNM stated that the maintenance of high standards of care and compassion is due to this commitment from the staff. Continuing education is planned on an annual basis, including all mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. There are 31 caregivers two are on level one, two level two, 17 level three and 10 have completed level four. One caregiver is also the activities coordinator. Four of eight registered nurses are interRAI competent to complete the required interRAI assessments on admission and six monthly thereafter. All staff have completed first aid training and this is maintained two yearly. Registered nurses can attend elective study days and training as well as being involved in the in-house in-service education/training for all staff. Focus on education is an ongoing strength of this service and is acknowledged as a continuous quality improvement.</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>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). Observations of six weeks of staff rosters identifies that the facility adjusts staffing levels to meet the changing needs of residents. Staff are replaced in any unplanned absence. An afterhours on call system is in place with staff interviewed reporting that good advice is available when needed. The GP is also on call 24/7 for this service. The service does not use bureau staff. Care staff reported there were adequate staff available and teamwork is promoted. Family and residents interviewed supported this. All staff (as per Standard 1.2.7) have completed first aid training.</p> <p>Dedicated kitchen staff cover all meals seven days a week. The activities coordinator works five days a week providing a stimulating programme for residents. Staff are responsible for the cleaning and laundry, and this</p>

		<p>is planned, with sufficient staff rostered on duty to cover these duties. One set staff member works in the laundry but is well supported by the care staff. Two staff complete the cleaning daily.</p> <p>Staffing on all shifts allows for the care staff to respond to call bells from the six independent living units, occupied by private renters on the same grounds as the care facility. The RNM confirmed there is always a registered nurse at the care facility and at night when a call bell is activated from the units a caregiver responds.</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' files are paper based and all staff including the GP document progress in the progress notes and medical notes, respectively. These documents were sighted in the residents' clinical records sighted. All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit. The residents' files were kept in locked cupboards. A shredder is used for destruction of unwanted confidential information.</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>Admission enquiries are managed by the RN manager, administrator, and the RNs. Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. NASC forms with the documented level of care were sighted in the residents' files reviewed. Prospective residents and/or their family/whānau are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. A tour of the facility is conducted at that time if desired. A record of all enquiries is maintained and a follow up is conducted by the RN manager.</p> <p>The service's brochure and information on the facility's website have detailed information on the services provided. Family/whānau and residents interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Signed admission agreements were sighted in the residents' records reviewed.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p>	FA	<p>The residents' discharge or transfer is planned and coordinated by the RNs and RN manager. An escort is provided as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of</p>

<p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>		<p>residents to and from acute care services. Open communication between all services, the resident and the family/whanau was evidenced in the transfer records sighted. The transfer records for a resident that was transferred to acute services demonstrated that appropriate information was provided for the ongoing management of the resident. All referrals were documented in the progress notes. Family of the resident reported being kept well informed during the transfer of their relative.</p> <p>The RN manager stated that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>Lady Elizabeth Home and Hospital has a safe electronic medication management system in place that was observed on the days of the audit. The medication management policy is current and identified all aspects of medicine management in line with safe practice guidelines and current legislative requirements. Staff who administer medication had current medication administration competencies. A list of medication administration competent caregivers was maintained and was accessible to the RNs.</p> <p>The RNs observed administering medicines demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Medicines were stored safely in the locked cupboards and medicine trolley in the medication room. Staff have individual passwords to access the electronic medicine records. The medicine fridge temperature was monitored, and the reviewed records were within the recommended ranges.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN completes medication reconciliation upon residents' readmission from acute services and when medication is received from the pharmacy. Clinical pharmacist input is provided on request. Unwanted medicines are returned to the pharmacy in a timely manner; there were no expired medicines in stock.</p> <p>Controlled drugs were stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. A current staff signature register was sighted. Medication management training is provided annually with the last training conducted by the pharmacist on 27/01/21. The RNs reported that any medication errors are documented and appropriate investigations are completed.</p> <p>Three-monthly medication reviews were consistently completed by the GP, as evidenced on electronic medicine charts reviewed. Dates were recorded on the commencement and discontinuation of medicines. Evaluation of pro re nata (PRN) medicines administered were completed consistently.</p> <p>There were no residents who were self-administering medications at the time of audit. Appropriate processes were in place to ensure this was managed in a safe manner when required. Interviewed staff demonstrated</p>

		awareness of the medication self-administration process.
<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>	FA	<p>Residents' nutritional needs were identified on admission by the RNs. Special dietary requirements, including likes, dislikes and allergies were identified and accommodated in the meal plan. Records of residents' special dietary needs were kept in the kitchen. Special equipment, to meet residents' nutritional needs, was available.</p> <p>The food service is provided on site by three cooks assisted by kitchen hands and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns in a four-week cycle. The menu was reviewed by a qualified dietitian in December 2020. Recommendations made at that time have been implemented. The meals are served in two dining rooms and residents who do not want to go to the dining rooms can have meals served in their room as desired. The food is transported in baine-maries to the dining rooms for serving.</p> <p>The service operates with an approved and current food safety plan and registration issued by the Ministry of Primary Industries. Regular external food verification audits are completed' the most recent completed on 12 December 2020. Food temperatures were monitored appropriately and recorded as part of the plan. Fridge and freezer temperatures were monitored, and records maintained. The kitchen was clean, no expired food was found in the pantry and left-over food was covered and dated. The cooks and kitchen hands have completed a safe food safety and handling training. Food procurement is completed by the main cook through online ordering.</p> <p>The residents and family/whānau reported satisfaction with the food service, and this was verified in the satisfaction surveys sighted. Residents can provide feedback on the meals in monthly residents' meetings or as needed. Alternate food options are provided by request. On the day of the audit, residents were given enough time to eat their meals in an unhurried fashion. Regular kitchen staff and management meetings are held. Meeting minutes of these meetings were sighted.</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</p>	FA	<p>The RN manager stated that if a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family/whānau are supported to find an appropriate care alternative. The prospective resident and/or family will be advised of the reason for the decline and will be informed of other alternative services available or referred to NASC as appropriate. There is a clause in the access agreement related to when a resident's placement can be terminated.</p>

appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Nursing assessments were completed on admission using the organisation's assessment tools, such as, a pain scale, falls risk, pressure area risk, nutrition and continence assessments, as a means to identify any deficits and to inform care planning within 24 hours of admission. InterRAI assessments were completed within three weeks of admission, routinely six-monthly and when there was a significant change in the resident's condition. The sample of care plans reviewed had an integrated range of resident-related information. All residents had current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families/whānau confirmed their involvement in the assessment process.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.  Care plans evidenced service integration with progress notes, activities assessments, medical and allied health professionals' notations clearly written, informative and relevant. Changes in care required was documented and verbally passed on to relevant staff. Residents and family/whānau confirmed participation in the development and ongoing evaluation of care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation in care plans reviewed, observations and interviews verified that care provided to residents was consistent with their needs, goals, and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The interviewed GP confirmed the service seeks prompt medical input, that medical orders are followed, and care provided meets the needs of residents. Care staff confirmed that care was provided as outlined in the care plans. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.
Standard 1.3.7: Planned Activities Where specified as part of the service delivery plan for a consumer, activity requirements are	FA	The activities programme is provided by an activities coordinator (AC) with the support of two activities assistants. The AC coordinates the activities programme with the support of the RN manager and the programme is overseen by an occupational therapist. Residents' activity needs are assessed as part of the admission process with input from the resident and family/whānau to ascertain residents' needs, interests, abilities, and social requirements. The AC completes the activities care plans for all residents. The activities programme is regularly reviewed to help formulate an activities programme that is meaningful to the

<p>appropriate to their needs, age, culture, and the setting of the service.</p>		<p>residents through monthly residents' meetings and satisfaction surveys. The residents' activity needs are evaluated when there is a significant change in participation and as part of the formal six-monthly interRAI assessment and care plan review.</p> <p>A monthly calendar is posted on the notice boards around the facility. There is a big activities room/chapel that accommodates many residents at a time. Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents were observed participating in a variety of activities on the days of the audit. Activities on the programme included weekly church services, puzzles, exercises, walks, music, external entertainment, movies and special events such as birthday celebrations. The interviewed residents confirmed that they find the programme satisfactory.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated on each shift and reported in the progress notes by the caregivers in each shift and daily by the RNs. The caregivers reported that any changes noted are reported to the RN. This was confirmed in the handover observed and in residents' records reviewed.</p> <p>Routine care plan evaluations occur every six months following the six-monthly interRAI reassessment, or as residents' needs change. Where progress was different from expected, changes were made to the plan of care. Short-term care plans were consistently reviewed, and progress evaluated as clinically indicated for wounds, skin, and urinary tract infections. Multi-disciplinary review meetings were conducted regularly with the GP, pharmacist, and the nursing team. Residents and family/whānau interviewed confirmed being involved in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services is indicated or requested, the GP, RN manager or RNs sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the mental health team, radiology, and dietitian. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to the public hospital in an ambulance if the circumstances dictate. Urgent referral records were sighted in the residents' files reviewed.</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 substances. Appropriate signage is clearly displayed where necessary. Responsibility for maintenance is delegated to the assistant manager. A list of preferred contracted service providers was reviewed. The assistant manager and staff who handle chemicals have completed relevant education related to safe chemical handling. Certificates were sighted in the personnel records reviewed. Material data sheets were available where chemicals are stored and staff interviewed knew what to do should there be a chemical spill/event occur.</p> <p>Waste management arrangements are in place and 'skip bins' are collected regularly. Yellow sharps bins are used by the registered nurses for any sharps/needles and other disposable items. When full these are also collected by the same waste management company contracted.</p> <p>There is provision and availability of protective clothing and equipment, and staff were observed using this during the audit.</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>	<p>FA</p>	<p>A current building warrant of fitness (BWF) was sighted and expires 2 August 2021. This was displayed at the entrance to the home. Equipment electrical checks were completed on the 10 May 2021 and the bio-medical equipment checks and calibration was completed 5 May 2021 and the verification report was sighted. The hot water temperatures monitoring checks are performed across all services three monthly and random rooms are selected monthly by the assistant manager. There have been no changes to the facility since the previous audit.</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. All residents' rooms have a hand basin. Only one room has a full ensuite bathroom. All wings have a large bathroom with a shower and toilet for every four to five residents. There are also separate staff and visitors' toilets available. Appropriately secured and approved handrails are provided in the toilet and shower areas and 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>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. At the time of the audit, all bedrooms are single occupancy. There are no shared rooms. Each room has a wardrobe. Rooms are personalised with furnishings, photographs and other personal items displayed. The rooms are large enough to accommodate mobility aids and the use of hoists.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There are three large lounges available. In addition to this, there are small lounges and a quiet room/whanau room available. There is a large functions room/chapel area, and the room can be used for activities, functions and staff training/education. There is a sunroom between the functions room and a lounge/dining area which is well utilised by residents and referred to as the 'sun tunnel'. Lounge and dining facilities have appropriate seating for frail and older persons. There is large courtyard in the centre of the facility and other outside areas to utilise especially in the summer months for outside activities and walks around the garden. The grounds are well maintained. Table and chairs and shade are provided as needed with use of umbrellas in the summer months available.</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>	FA	<p>There is a designated laundry space with three washing machines and three clothes dryers. A set staff member covers the laundry service which operates seven days a week with the assistance of the care staff. The environment was clean and organised with clean/dirty designated areas. Chemicals are locked in in each service area with signage being available. Training is provided to all staff by product representatives from the contracted services and an eco-system is in place for the washing machines. All linen and clothes are put away daily. All residents at the time of audit reported the laundry is well managed and their clothes are returned in a timely manner.</p> <p>There are two care staff rostered on daily for cleaning duties to cover the facility. Staff interviewed have a good understanding of their role and infection prevention and control processes. Storage is provided for the cleaning trollies in the locked room when not in use. Personal protective resources are readily available, and staff were observed wearing this during the audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an</p>	FA	<p>Policies and guidelines (reviewed February 2021) for emergency planning, preparation and responses are displayed and known to staff. Disaster and civil defence planning guides and directs the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. The Ministry of Civil Defence and Emergency Management recommendations for the region are met in relation to appropriate stocks of water, power, emergency resources and food. Approximately 4000</p>

<p>appropriate and timely response during emergency and security situations.</p>		<p>litres of water are stored in two tanks. Emergency lighting is tested regularly. The service has its own generator if needed as a resource for a power outage if this occurs. There are adequate supplies of blankets, mobile phones, food and first aid supplies to meet the requirements of 55 residents.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 17 April 2014 and no changes have been made to the building footprint since this time. A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service; the most recent being held 14 June 2021. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures.</p> <p>Call bells alert staff to residents requiring assistance. The assistant manager completes call bell audits and sends a report to the RNM. The call bell system is serviced regularly. Residents and families interviewed reported staff respond promptly to call bells.</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>All residents' rooms and communal areas are heated and ventilated appropriately. Electric 'fire like' heaters supply heating for the two main lounges. Four heat pumps are also located in different parts of the facility. Wall heaters are positioned in all hallways and eco panels in all residents' rooms. A heat pump is situated in the education/board room. Rooms have natural light and opening external windows. An even temperature was felt throughout the facility.</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>	<p>FA</p>	<p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff, and visitors. The programme is guided by a comprehensive and current infection control manual, with input from external specialists. The infection control programme is reviewed annually; last reviewed in January 2021.</p> <p>The RN manager is the designated infection control coordinator (ICC), whose role and responsibilities are defined in their job description. The ICC has delegated some responsibilities for IPC to two RNs. Infection control matters, including surveillance results, are reported monthly to all staff, and tabled at the management and staff meetings. The IPC committee includes the RN manager, two RNs, a caregiver representative, an enrolled nurse and laundry representative.</p> <p>There is signage at the main entrance to the facility requesting anyone who is or has been unwell with flu like symptoms in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The interviewed staff understood these responsibilities. The Covid-19 contact tracing QR code was available at the entrance to the</p>

		facility.
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICC has been in this role for more than 20 years and has appropriate skills and knowledge for the role. They have attended relevant infection prevention and control education, as verified in training records sighted. Additional support and information are accessed from the infection control team at the DHB, the community laboratory, the GP and public health unit, as required. The ICC has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection. Adequate resources were sighted on the days of the audit. Updated information on COVID-19, including vaccination information was available and easily accessible to staff and residents. All eligible residents have received the COVID-19 vaccine. There are processes in place to cohort staff and residents if there is an outbreak within the facility.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were reviewed in January 2021 and included appropriate referencing.</p> <p>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. Hand washing and sanitisers were readily available around the facility. The interviewed staff demonstrated knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service</p>	FA	<p>Interviews, observation, and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. Education was provided by the continence nurse from the DHB. Content of the training is documented and evaluated to ensure it is relevant, current, and understood. A record of attendance was maintained, and high staff attendance levels were demonstrated.</p>

<p>providers, support staff, and consumers.</p>		<p>There was evidence that additional staff education has been provided in response to the COVID-19 pandemic in March and April 2020.</p> <p>Education with residents is on a one-to-one basis for any infections and in groups during residents' meetings and this included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather. This was verified in residents' meeting minutes and short-term care plans sighted.</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>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, multi-resistant organisms, and the upper and lower respiratory tract. Infection reports are completed for all infections and the ICC reviews all reported infections. New infections and any required management plans are discussed at handover, to ensure early intervention occurs. This was confirmed in the handover observed and in staff interviews.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Six-monthly hand hygiene audits are completed for all staff, and corrective actions were implemented as required. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Trends for the current year are compared with the previous year. There were no infection outbreaks reported since the last audit.</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>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provided guidance on the safe use of both restraints and enablers. The facility was restraint free with no enablers or restrains in place at the time of the audit. The restraint coordinator (RN) interviewed would provide support and oversight for enabler and restraint management in the facility. should they be used. The role and responsibilities of the restraint coordinator are described in policy.</p> <p>Enablers are described in policy as the least restrictive and are used voluntarily at the resident's own request.</p> <p>Staff interviewed understood that restraint would only be used as a last resort when all alternatives had been explored. The restraint register sighted identified that the last restraint use was 2 October 2020.</p>

## Specific results for criterion where corrective actions are required

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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.

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to</p>	CI	<p>Education planning 2020/2021, the competency register and the in-service/education records were reviewed along with individual education records. The RNM who is responsible for the in-service education programme was interviewed and discussed how the programme is developed and implemented. Careerforce training has been part of the education programme for many years and most staff have achieved qualifications, so the focus is now on more individual learning. The planning is a team effort due to English being the second language of most staff. Much teaching and encouragement is undertaken to achieve the outstanding results reviewed. Daily updates and ‘pod’ lectures in small groups have worked well especially last year with the Pandemic and Covid-19 lockdowns. This continued to upskill and encourage all levels of staff with education, especially in relation to infection prevention and control at the time and this continues to be paramount. Education sessions are provided in blocks of three to four weeks with standard themes. Knowledge of</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the comprehensive evidence that ongoing education is provided and attended by all staff. The RNM ensures the approach to learning is encouraged and varied to maintain staff interest. The training is provided by the RNM, RNs, the GP, pharmacist, physiotherapist and other health professionals to ensure person centred care from the residents’ perspective. The training is provided so that the staff fully comprehend and focus on the experience and learn to understand care delivery from the resident’s point of view. Staff reported that they are more informed about what it feels like to have someone else providing care for them. Improvements and high standards of care provided are continually</p>

consumers.		<p>medical conditions relating to current care needs are emphasised and are important for all levels of staff. Person-centred care is a theme that runs through all teaching and meeting sessions and is the key to the continued person centred approach and success.</p>	<p>acknowledged from the individual residents and family members interviewed. Staff feel proud to maintain this standard of service delivery. Registered nurses also reported a better understanding of advance directives and informed consent.</p>
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End of the report.