St Clair Park Residential Centre Limited - St Clair Park Residential Centre

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 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:	St Clair Park Residential Centre Limited
Premises audited:	St Clair Park Residential Centre
Services audited:	Rest home care (excluding dementia care); Dementia care; Residential disability services - Psychiatric
Dates of audit:	Start date: 12 July 2021 End date: 13 July 2021

Proposed changes to current services (if any): The dementia wing has a total of 15 beds. Initially on opening, the DHB had approved a maximum of 13 dementia level residents. The thirteen residents can and have occupied any of the 15 beds. All fifteen beds were assessed as part of this audit as being suitable for dementia level care. This increases overall bed numbers to 41.

Total beds occupied across all premises included in the audit on the first day of the audit: 34

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

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

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

General overview of the audit

St Clair Park Residential Centre provides rest home, dementia and residential disability (psychiatric) level care for up to 39 residents. On the day of the audit there were 34 residents. In the 15-bed dementia unit (only 13 currently in use), the two extra rooms were verified as suitable for residents in the unit. This increases the total overall beds to 41.

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

St Clair is managed by a manager with prior experience in mental health and managing health services. She has been in the role since December 2017. The manager is supported by an administrator, two registered nurses, a quality consultant and a team of care staff. Feedback from residents and families was positive about the care and services provided.

A significant number of improvements have been noted as implemented since the last audit. Two improvements were identified in relation to consumer participation and the quality management system.

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.

Complaints and concerns are managed, and a complaints register is maintained. Residents and relatives feel well informed and are comfortable discussing issues with the manager.

St Clair Park incorporates the Code of Health and Disability Services Consumers' Rights (the Code) into its policies and procedures, and into everyday practice. Resident information packs include specific information such as the Code of Rights, advocacy services and complaints processes. Residents are supported to understand their rights and report good communication from staff.

Residents are treated with understanding, dignity and respect. Privacy is respected and ongoing family contact and involvement is encouraged, with families involved in decisions regarding care and support as appropriate. Cultural and spiritual values, beliefs, and wishes are identified and supported. Residents participate in a range of activities, both within the service and in the wider community. They are encouraged and supported to be as independent as possible, and to make their own choices in all aspects of their life.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.

The quality and risk management programme includes service philosophy, goals and objectives. Meetings are held to discuss quality and risk management processes. There is a health and safety management programme available to guide staff. Resident meetings are held regularly. Incidents and accidents are reported. There are human resources policies to support recruitment practices. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. An education and training programme is implemented and well-attended. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Resident meetings are held bi-monthly in the Ashwood (mental health) and Middleton (rest home) units. There are policies to support consumer and family involvement at all levels of the service.

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.

The registered nurses are responsible for each stage of service provision for all residents funded by contracts that are not mental health. The assessments, initial and long-term nursing care plans are developed in consultation with the resident/family/whānau. The manager oversees the assessment, goal and relapse prevention planning in conjunction with the senior support workers for residents funded under mental health. The registered nurses complete assessment and care planning of any medical care needs for the residents in the mental health unit.

The activity programme is developed to promote resident independence and social interaction. Residents interviewed spoke positively about the activity programme.

Medication policies reflect legislative requirements and guidelines. Staff responsible for administration of medications complete education and medication competencies. Medications are stored appropriately.

Planned activities are appropriate to the group setting with focus on community involvement for the residents of the mental health unit. The residents and relatives interviewed commented positively on the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Meals are prepared by an external contractor and delivered to the facility. Nutritional requirements are met. Nutritional snacks are available 24 hours a day. Special diets are catered for on a case-by-case basis.

Safe and appropriate environment

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

The building at St Clair Park has a current building warrant of fitness. Procedures are in place for emergencies, laundry use and safe management of waste and hazardous substances. Maintenance systems are in place. Emergency, security and safety systems and processes are up to date. Protective clothing and emergency food supplies are available. The building is appropriately heated and ventilated. Residents stated bathroom, personal space areas, outside and communal areas are suitable for their needs. Chemicals are safely stored.

There are processes in place to ensure a safe environment for residents, staff and visitors are appropriate to the service delivery setting.

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.

St Clair Park remains restraint free. The manager is the restraint coordinator. Education around restraint minimisation, managing challenging behaviours and falls prevention is provided during orientation and 12-24 months thereafter.

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.

St Clair Park has an infection control programme in place which has been reviewed annually. The infection control programme is designed to link to the quality and risk management system. Records of all infections are maintained electronically, analysed for trends and discussed at all meetings.

Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. The type of surveillance undertaken is appropriate to the size and complexity of the facility.

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	46	0	2	0	0	0
Criteria	0	114	0	2	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	There is a current Code of Rights policy. Staff interviewed receive training on the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during orientation and alternate years, thereafter. Interviews with one facility manager and eleven staff (two registered nurses (RNs), two key workers, three care givers, one diversional therapist, one administrator, one maintenance, one quality consultant) confirmed their understanding of the Code and its application to their job role and responsibilities. Care staff presented examples of how the Code is applied in the everyday care given to residents. Seven residents (four rest home and three mental health) and two family members (one dementia, one rest home) interviewed were happy with the care and support provided. Observations during the audit noted that staff interacted with residents in a respectful and supportive manner.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed	FA	Systems are in place to ensure residents, and where appropriate their family/whānau, are provided with appropriate information to make informed choices and informed decisions. The care staff interviewed demonstrated a good understanding in relation to informed consent and informed consent processes. Each resident receives an admission pack prior to admission to the facility. There are established informed consent policies/procedures and advanced directives. General consents (including outings and indemnity) were obtained on admission as part of the admission agreements. Specific consents were sighted such as influenza vaccines.

choices and give informed consent.		Advance directives if known, were on the resident files reviewed. Resuscitation plans were sighted in all files. The GP deemed if the resident was competent or not and a medically indicated decision was evident for incompetent residents. Copies of enduring power of attorney (EPOA) were present and activated as required.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information about the Nationwide Health and Disability Advocacy Service is brought to the resident's attention on admission. Residents receive an information pack that includes information relating to the Code, which includes reference to advocacy services on admission. Residents confirmed that they were aware of information available to them and how to access it if and when required.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Family and visitors are welcomed to visit during sociable hours. Communal areas are available to host visitors. Resident's access and engage in a range of community services and activities and this was observed during the audit, with residents telling stories of the community activities they had taken part in. Residents interviewed stated they access other services in the community for various reasons and are assisted to do so by staff as relevant to their health and wellbeing. The service provides assistance to ensure residents are able to participate in as much as they can safely and desire to do. This includes resident's visits to the local mall, visiting the library and attending community groups. The service has a van to transport residents to destinations in the community. Some residents use public transport to attend community events. Residents and family confirmed that visiting, attendance at, and participation in community activities was encouraged.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedure are being implemented. Residents and their family/whānau are provided with information about their right to make a complaint and the complaints process on admission. Complaints forms are available on request at reception. A complaints/suggestions box in located at the entrance. The residents and families interviewed confirmed their awareness of the complaints process. They advised that they feel comfortable lodging a complaint if necessary and are comfortable discussing concerns with the manager and staff. An electronic complaints register is maintained. No complaints were lodged in 2020 and three have been reported in 2021 (year-to-date). All three complaints were addressed in a comprehensive and timely manner, meeting requirements determined by HDC. They are documented as resolved. Missing was

		evidence in staff meeting minutes to indicate that staff have been kept informed (link 1.2.3.6).
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The Code and information about national advocacy services is given to residents and their family on entry to the service. The Code in Maori and English posters and information on advocacy services is displayed at the entrance of the facility and in the dementia (Cargill), mental health (Ashwood) and rest home (Middleton) units. The residents welcome pack on entry contains a copy of the Code and the Nationwide Health and Disability Advocacy services. Staff confirmed they clarify rights and advocacy with residents on admission and at the residents' meetings. Residents also keep this information in a place of their choosing. Interviews with residents, four from Middleton and three from Ashwood confirmed they were aware of their rights. This was verified by family and included family from Cargill. Residents' meetings, Middleton and Ashwood, are held bi-monthly; minutes were sighted.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	There is current policy on privacy and confidentiality, and abuse and neglect. Education records and staff interviews confirmed that staff receive education pertaining to privacy, respect, abuse and neglect. Residents have their own bedroom and during the audit staff were observed to ask permission to enter a residents' room. Residents and family interviewed advised that personal belongings are respected. All staff address residents by their given name or preferred name, they knock on the door before entering residents' rooms, and they speak to residents in a tone and manner that is respectful as observed during the audit. Residents are supported to be as independent as they are able. There was no evidence of abuse or neglect and residents and family interviewed spoke positively about the staff and the service. Resident surveys are undertaken annually, and results sighted confirmed a high level of satisfaction.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	There is a current Māori health and cultural policy that staff interviewed discussed. Policy identifies health gain priorities for Māori. Links are in place with Kaumatua who can be available when required. Services delivered by the provider and barriers within the control of the organisation are brought to their attention, are discussed and eliminated in a professional manner. Residents' cultural needs are identified in the referral information. Staff regularly review cultural needs with Māori residents. The organisation fosters a recovery approach and acknowledges the Treaty of Waitangi. Māori staff support residents who identify as Maori. Staff training records showed that Treaty of Waitangi and cultural training is routine. There were four residents who identified as Maori on the day of the audit, cultural preferences were identified in the care plans reviewed.

Standard 1.1.5: Recognition Of Pacific Values And Beliefs Pacific consumers have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The services policy and procedures support the organisations commitment to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Pacific residents are valued and fostered within the service. The policy includes links with external Pacific organisations. During this audit there were no residents who identified as Pacific living at the facility. Staff interviewed were aware of the importance of the relationships between the Pacific consumer, their family and their community in the delivery of care for Pacific residents. Management and staff can describe links with Pacific representatives.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	Staff interviewed were aware of residents' individual needs, values and beliefs and these were noted in resident files reviewed. Residents reported that staff are responsive to their cultural needs. They stated that they are supported to access cultural and spiritual activities important to them. Support is provided to attend spiritual gatherings. Staff explained how they acknowledge different views of spirituality as part of the residents' wellbeing and personal plans. St Clair Park has a workforce that represents the cultural composition of the regional area. This allows residents access to staff of their own culture if they wish.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There is policy and procedure to ensure residents are free from discrimination. Information on resident rights is displayed throughout the facility and residents are provided with an information pack on entry to the service which covers residents' rights. Staff interviewed described ways they work with residents to support independence and responsibility. The organisation encourages open communication with staff, residents and family to promote early identification of any concerns. Processes are in place to prevent financial and other exploitation of residents. Professional boundaries are reconfirmed through education and training sessions, staff meetings and performance management if there is an infringement. Residents engage socially in the community and amongst the public. This helps to break down barriers of social stigmatisation and discrimination.
Standard 1.1.8: Good Practice Consumers receive services	FA	St Clair Park is a preferred provider of residential care for those people other services cannot or will not provide services for. Since the previous audit, RN hours have increased to 64 hours over six days per week (Monday – Saturday). The service focuses on the residents' strengths and their abilities and interests. This

of an appropriate standard.		has a positive impact on their independence and recovery. The service purchased Healthcare Compliance Solutions Ltd. standard operating procedures which includes an electronic resident management system, total quality management programme and online learning tools for staff. An external quality consultant, who visits two days per month, provides quality and risk management support. The service also receives support from the district health board which includes visits from the mental health team and nurse specialist's visits. Physiotherapy and dietitian services are accessed when required. The service has links with the local community and encourages residents to remain as independent as they are able. The GP interviewed is satisfied with the level of care that is being provided. Although there has been a reported high turnover of staff in the past, staff interviews confirmed that the facility manager has been successful in building teamwork amongst the staff. Staff remarked on an improved staff culture and stated that they feel supported by the RNs and manager. Resident survey results (February 2021) overall reflect satisfied residents. This was confirmed during interviews with residents and families. A recent quality improvement initiative has been reducing the amount of prn (as required) meds for a select group of four residents with no adverse consequences.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Resident files evidenced residents are informed of any change in care provision or event and they are included in care planning and goal reviews. Staff confirmed their understanding of open disclosure. The service has access to interpreters where required. Resident house meetings, monthly cover basic house rules, menu input and the opportunity to raise any issues/suggestions they may have and to be kept informed with matters relating to the facility. The service has an open disclosure policy and staff interviewed confirmed their understanding of open disclosure. Residents and family/whanau members confirmed communication with staff was open and effective. Staff described working collaboratively with residents including mutual open and honest communication.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	St Clair Park Rest Home is a privately owned residential care facility that provides care across three service levels (rest home, dementia and residential disability-psychiatric). The number of certified beds available is 39 with two additional beds assessed in the dementia unit as suitable for dementia level of care with increase overall bed numbers to 41. The service is divided into three units. The 15-bed Cargill unit (dementia level care), 18-bed Ashwood unit (essentially mental health) and 8-bed Middleton unit (essentially rest home). At the time of the audit there were 34 residents (11 rest home level, 10 dementia level, and 13 on a residential disability – psychiatric (mental health) contract. Two residents (rest home) were on ACC, two residents (rest home) were on a chronic health conditions-long term services contract (LTS-CHC), one

		resident (rest home) was on a young person with a disability (YPD)/intellectual contract, and the remaining aged care residents were on an age-related residential care contract. St Clair Park's 2021 business, quality, and risk management plans, which include a mission, and business objectives and values, are being implemented. Business goals are regularly reviewed with the three directors (owner, manager and manager's spouse). Goals are also reviewed regularly with the quality consultant and staff (where applicable). The manager (non-clinical) has been in the position for over three years. She has a degree in social services and over 18 years' experience in health services, which includes six years of management experience (2003-2009). Her background includes working with intellectually disabled individuals and those with mental health conditions. She has completed over eight hours annually of training relating to managing an aged care facility. She is a member of the Aged Care Association. She is supported by an administrator (human resources, accounts), two RNs and an external quality consultant.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	In the absence of the manager, a designated RN is second in charge. In the absence of the full-time RN, the second (part-time) RN would increase her hours and hold responsibility for clinical operations. The administrator is responsible for all non-clinical operations with additional support provided by the quality consultant.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	PA Low	A quality plan (2021) is being implemented. Quality goals and objectives are centred on a resident focus; provision of effective activities programmes; and meeting all certification and contractual requirements. The quality programme is overseen by the manager with support provided by an external quality consultant who visits the facility one day per month. St Clair Park has purchased and implemented Health Compliance Solutions Ltd (HCSL), a quality assurance system for aged residential care. A system for document control is being implemented. Policies and procedures are in an electronic format and are reviewed two-yearly (at a minimum). Quality improvement processes on HCSL currently being utilised by the service include adverse event and infection control data collection and management, and complaints management. An internal audit programme is being completed manually (hard copy) with occasional gaps identified in completing a selection of the audits scheduled. Corrective action plans are developed, implemented and signed off when

		service shortfalls are identified but corrective actions are not consistently minuted in the applicable meetings (e.g., quality meetings, clinical meetings, residents' meetings). There is a dedicated health and safety officer (manager) who leads the health and safety programme. She has completed stage one, two and three training. All staff complete an annual health and safety competency questionnaire every year. Contractors are provided with an on-site health and safety induction relevant to health and safety. The hazard register is regularly monitored to ensure controls are in place. Resident surveys were last completed in February 2021 with 11 respondents. Survey results indicate that the majority of residents are satisfied with the service. Although survey results were not included in the staff meeting minutes, there was evidence in meeting minutes of corrective actions being addressed around two shortfalls identified in the survey results, food and building maintenance. Initiatives are in place around managing residents with challenging behaviours. Falls prevention strategies are also being implemented for residents which include discussing those residents deemed at risk of falling at handovers and increasing the frequency of monitoring for residents at risk of falling.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	There is an incident/accident reporting policy that includes definitions and outlines responsibilities including immediate action, reporting, monitoring, corrective action to minimise and debriefing. Individual incident/accident reports are completed for each incident/accident with immediate action noted and any follow-up action(s) required. A review of 17 incident/accident forms (skin tears; witnessed and unwitnessed falls, medication errors, challenging behaviours, bruising) identified that the incident/accident forms are fully completed and include follow-up by a registered nurse. The manager follows up and signs off on resident episodes of challenging behaviours for residents under the mental health contract. Neurological observations are completed in a consistent manner for residents who experience an unwitnessed fall or sustain an injury to their head. The manager was able to identify situations that would be reported to statutory authorities. There have been no outbreaks since the previous audit. Section 31 reports have been completed since the previous audit for one assault, one unexpected resident death, one death of a person un the Mental Health Act, and one episode of RN staffing not available/disruption to service.
Standard 1.2.5: Consumer Participation Consumers are involved in the planning, implementation,	PA Low	St Clair has monthly residents meeting; minutes reviewed indicated residents have input into the service. The facility manager has an open-door policy. Residents and staff interviewed stated that residents feel confident talking to staff and management about services. A resident and a relative satisfaction survey have been implemented with a positive result from residents. The relative survey has not received any responses. The service has policies and procedures for resident input into the service, at the time of the

and evaluation at all levels of the service to ensure services are responsive to the needs of individuals.		audit the policy was not fully implemented. The family participation processes described in policy are not implemented. The service is currently looking to fill the consumer advisor position as per policy. Residents said the service followed up and discussed with them their suggestions for improvement/s. All staff with lived experience have position descriptions, receive training and supervision.
Standard 1.2.6: Family/Whānau Participation Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals.	FA	There is a family/whanau participation policy and procedure that describes the ways family/whanau can participate. Staff and family/whanau interviewed stated they are encouraged to be involved as much as possible with their family/whanau at an individual level, to attend admission, and reviews of care plans. Most relatives do not have close involvement with the resident or the service. Family/whanau involvement with decisions relating to policies, protocols, planning, and implementation is through a family member at management level and in the team. Family can also have input by way of verbal feedback to staff, use of letters, phone calls and visits, and the availability of the complaints process. Staff interviewed stated that they are aware of the importance of family/whanau involvement in the resident's recovery/care and actively support this wherever appropriate. Residents and family/whanau interviewed stated that they were comfortable with their level of participation. Relatives are invited to complete an annual satisfaction survey although the response rate is low. There is regular contact from the service to families around resident updates. Staff employed with lived experience have position descriptions, receive training and supervision.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resource management policies include the recruitment and staff selection process. Relevant checks are completed to validate the individual's qualifications, experience and veracity. Current practising certificates for health professionals is retained (e.g., RNs, nurse practitioner, GP, physiotherapist, podiatrist). Six staff files reviewed (two caregivers, one support worker, one cleaner, two RNs) evidenced that reference checks are completed before employment is offered. Also sighted were signed employment agreements and job descriptions. The service has implemented an orientation programme that provides new staff with relevant information for safe work practice. Care staff complete an orientation programme that includes assessing their competency prior to working independently with the residents. Staff education and training includes regular in-services, online self-directed learning and competency assessments that cover a range of skills including (but not limited to) medication management, infection control, code of rights, abuse/neglect, safe food handling, health and safety, restraint minimisation and managing challenging behaviours. Evidence of the completion of compulsory education was also sighted for staff working with residents under a mental health contract including but not limited to: family inclusiveness, mental health conditions, mental health advocacy, recovery principles, Pacifica values and beliefs, chemical management). Four of eight caregivers working in the dementia unit have completed their required dementia qualification.

		Two are in the process of completing theirs and have been employed to work in the dementia unit for less than 18 months. Two recently employed staff have not yet enrolled. Staff confirmed that they have attended in excess of eight hours of education and training per year. Both RNs have completed their interRAI training. There is a minimum of one first aid trained staff available 24/7.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	A staffing policy is being implemented. The DHB mental health nurse practitioner is in weekly contact with the service, and is the combined role of the prescriber, case manager and responsible clinician for the mental health residents. A general practitioner also visits the care facility one day a week. Both the Nurse Practitioner, and GP take calls when not available on site. There are two registered nurses. One RN is employed Monday – Friday and the second RN works extended hours on Wednesdays and Saturdays. The facility manager provides oversight for the mental health residents and is on call 24/7 when not available on site. At the time of the audit, there were no staff vacancies for permanent positions. The service is divided into three units with one unit (Cargill) a secure dementia unit. Each resident under a mental health contract has an identified key worker. A key worker holds a minimum of a level three Careerforce qualification (or its equivalent) with evidence to indicate that they are working towards a level four qualification in mental health and addictions. Caregivers are assigned to residents under an aged care contract (rest home or dementia level); and key workers and support workers are assigned to residents under a mental health contract. They are collectively referred to as care staff. Ashwood unit (five rest home level who have moved from mental health and twelve mental health): Two care staff work on the AM shift and one care staff works on the PM shift with a third staff rostered across both the AM and PM shifts (1300 – 2130). One care staff is rostered on the night shift. Middleton unit (six rest home level and one mental health): Two care staff are rostered on the AM shift, and two short shift caregivers (1500 – 2130; 1545 – 2115) are rostered on the PM shift with oversight provided by the Ashwood staff after 2115. One care staff is rostered on the night shift. Cargill (secure dementia) unit (10 dementia level): Two care staff are rostered on the AM shift, and two are rostered on the PM shift (one eight-hour shift and one short shift (1615 – 2115) and a cleaner from 0900 - 1300. One care staff covers for the night shift. Note: The DHB has approved a maximum of 13 dementia level residents. The dementia wing has 15 beds that were assessed during the audit as suitable for dementia level of care. The facility manager confirmed that staffing levels will be reviewed if the DHB approves an increase in the number of dementia level residents from 13 to 15 Interviews with the residents, family (whānau) and staff confirmed staffing meets residents' needs.

Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information is readily accessible in an electronic format with individual password protection. Any hard copy resident information is stored where it cannot be accessed by people not authorised to do so. Resident files reflect service integration. Electronic back-ups are undertaken using cloud-based technology. Progress notes are completed on the electronic HCSL system and notes the person making the entry by their individual log-in.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	The service has admission policies and procedures in place to support admission. The dementia unit and rest home residents are assessed prior to admission by the need's assessment team. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The facility manager and RN screen all potential residents prior to entry and records all admission enquiries. The admission agreement form in use aligns with the requirements of the ARC contract. Exclusions from the service are included in the admission agreement. Mental Health access processes and entry criteria are outlined in policy. All referrals are made by single point of entry (SPOE) by the mental health service and discussed on an individual basis by the DHB nurse practitioner assigned to St Clair Park, with the facility manager and the RN to ascertain suitability. Residents come for an initial visit where possible, usually with family or the case manager. All potential residents have a needs assessment completed by the service coordination service prior to referral. Each new or prospective resident is given an information pack that is part of the admission agreement. The resident information includes information on the Code, health and disability advocates, information on how to make a complaint and consent form.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The residents and their families are involved for all exit or discharges to and from the service. Mental Health: There have been no planned discharges since the previous audit, as appropriate for this resident group. The six-monthly MD review includes discharge planning if appropriate. One resident has a goal around discharging.

Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	Twelve electronic medication charts were reviewed across dementia, rest home and mental health. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complied with the medication management policy for the medication rounds sighted. Medication competent registered nurse, and medicine competent caregivers/support workers administer medicines. The facility uses robotic sachets and blister pack medication management system and Medimap. The registered nurse reconciles the delivery of medications and informs the pharmacy of errors. There was evidence of three-monthly reviews by the GP. Medications are prescribed and charted in line with guidelines for all residents admitted for long-term care. 'As required' medications include indications for use. There are two residents self-administering, competencies and safe storage are in place. The temperatures are checked in the medication storage areas and also the medication fridge.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	All food is prepared and cooked off-site by an external contractor and delivered in hot boxes at mealtimes. It is then transferred into bain-maries or served from the hot boxes, temperature checked and electronically recorded before being served by support workers and caregivers. If the temperature checks have not occurred or are outside the range, an email is sent to the contractor and the facility manager. A dietitian reviews all menus for the contracted food services company. A current food control plan is in place. Staff have completed food safety training. Special diets and likes and dislikes are catered to as reported by staff and residents interviewed. Changes suggested/requested by residents are sent to the kitchen and the menu altered accordingly. Meals are appropriate to the client group, with individual meals supplied that cater to likes and dislikes and nutritional requirements. Breakfast is served as residents are ready for it. There is a wide variety of fresh fruit and snacks available for residents. Morning and afternoon teas are delivered with the main meals. All food in the fridges throughout the facility was dated and stored in line with guidelines. Fridge and freezer temperatures are regularly taken, recorded, monitored and adjustments made as required. Food and meals are discussed at resident meetings. Residents and relatives interviewed were complimentary of the meals provided. Snacks are available 24 hours in the dementia unit.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the	FA	The facility manager reported there had been no decline entry in the rest home or dementia since the last audit. There is policy and procedure where entry is declined. The service records the reason for declining service entry to potential residents and communicates this decision to potential residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice. Mental health residents have not been declined entry unless there is a lack of suitable placements, although

consumer and/or their family/whānau is managed by the organisation, where appropriate.		residents may decide not to come to the service after the initial tour. They are then referred back to the need's assessment service. All declined entries are discussed with referrers.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Rest home and Dementia: Four resident files reviewed included interRAI assessments and other key assessments including (but not limited to) challenging behaviour, pain. Files reviewed identified that risk assessments had been completed on admission and had been updated at the time of the care plan review. Mental Health: Two resident files reviewed included needs assessments and ADL assessments. Strength's assessments have been completed for all residents with goals and a plan developed. These have been reviewed three-monthly. Cultural assessment is completed as part of admission.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Rest home and Dementia: Four long-term resident files reviewed had an individualised care plan in place. Each electronic care plan included interventions under a number of key headings. Interventions were informed by the assessment process and were comprehensively documented to describe the care and support needed. Short term care plans are utilised for acute changes of care and updated into the long-term care plan when needed. De-escalation techniques are developed for residents with behaviours that challenge. Mental Health: The two mental health files reviewed included support plans with short and long-term goals. Both files reviewed included an ADL ability/support plan which identified support and assistance needed. Early warning signs and relapse prevention signs were on file and reviewed as part of the support plan review.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Rest Home and Dementia: When a resident's condition alters, the registered nurse initiates a review and if required a GP visit. If external nursing or allied health advice is required, the registered nurse will discuss with the GP, who sends the referral. Residents are supported to attend clinics such as diabetic clinics. Wound care, district nursing and continence specialists are available on request. There are currently two wounds being managed. Wound assessment and management plans were in place. A wound register monitors when wounds are resolved. Adequate dressing supplies were sighted to be available in each of the three units. Continence products were available and resident files included urinary continence assessment, bowel management and continence products identified for day use, night use and other management. Resident's weight is monitored monthly and documented on the Medimap observation chart. Monitoring

		forms sighted included (but were not limited to); behaviour, falls, bowels, daily living activities, weight and vital signs. Residents and relatives interviewed were happy with the support provided to them. Mental Health: The nurse practitioner (NP) for mental health works closely with the registered nurse and liaises regularly with the GP. He works as case manager for the residents and provides support and oversite at least weekly. The service has support from a quality consultant who also specialises in mental health. All residents at St Clair Park have diagnoses of mental health conditions. Many also have age-related medical problems. The support and care plan are designed to meet the person's individual needs and goals. The residents are supported to maintain outside interests and community involvement. Resident goals often include achieving community activities. Three residents interviewed under mental health contracts confirmed satisfaction with their home and the support provided.
Standard 1.3.7: Planned Activities 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.	FA	The service employs two diversional therapists (DTs) to meet the activity needs of the residents. Between them they cover seven days per week a total of63 hours in Dementia and 16 hours between Ashwood and Middleton units. Support staff cover activity delivery in all three units (dementia, aged care and mental health) as a part of the programme. The staff follow a monthly activity schedule appropriate for each unit which the DTs oversee. Residents were observed completing chores to support a safe and tidy environment. Other tasks that supported residents to become independent including Mental Health residents being in charge of their own laundry. Regular monthly resident meetings were held where resident have input into activities. Residents expressed satisfaction with their daily routines and the activities they participated in. There are a variety of games and care staff have access to these when the DT is not present. Care staff also provide impromptu activities to engage residents and support other behaviour management techniques. The DTs develop the activities programme and provide support to care staff. The programme is planned monthly. Individualised activity assessments and activity plans are completed. Activities are delivered to meet the cognitive, physical, intellectual and emotional needs of the residents. The service receives feedback and suggestions for the programme through surveys and one-on-one feedback from residents, and as appropriate from families. Residents and families interviewed spoke positively about the activities programme. The programme includes outings in the car, church services, and arts and crafts, happy hour and entertainers that visit the facility. There are resources available for staff to use for one-on-one time with the residents and for group activities. Residents are supported to engage in activities of their choice in the community; these include the octagon club, art centre, pottery classes, and going out for meals. Residents commented positively on the activities provided. Residents also mentioned listening to music, knitting, watching television, colouring

		in, going for walks, and having conversations. They conveyed being happy with what they were doing. The organisation ensured that activities contribute to the residents' recovery and are individualised.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Rest Home and Dementia: Care plans reviewed had been evaluated by RNs six-monthly, and overall when changes to care occurred. Written evaluations describe the resident's progress against the resident's (as appropriate) identified goals. Care plans for short-term needs are evaluated and either resolved or added to the long-term care plan as an ongoing problem. The GP reviews residents at least three-monthly or when there is a change in health status. Six monthly multidisciplinary care plan reviews occur. Mental Health: There is an implemented process of formally reviewing recovery plans, goals and outcomes both with the resident and in a multidisciplinary setting. Evaluations were completed three-monthly in the two files reviewed. The review included the resident and with their consent, their family/whānau (Resident – action plan review meeting).
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Referral to other health and disability services is evident in the resident files sampled. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Residents requiring a higher level of care are referred to the needs assessment service for re-assessment as described by the registered nurse. The registered nurse initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. There are close links with mental health services. Referral documentation is maintained on resident files.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during	FA	Staff follow a documented policy for the safe and appropriate storage and disposal of waste, infectious or hazardous substances that complies with current legislation and territorial authority requirements. Chemicals are required to be and are stored in a locked chemical/cleaning cupboard. No flammable liquids are kept on-site. Staff have access to personal protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers. The systems in place ensure a hygienic environment and are known to staff and are monitored by staff and the health and safety representative.

service delivery.		
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	There are three separate units in one building, one aged care, one secure dementia and one mental health that are linked by passages. This allows residents to pass each other safely. There is safe access to all communal areas and outdoor areas. There is outdoor seating and shade. The dementia unit has a secure outdoor area. There is good indoor outdoor flow and areas to wander. Staff stated they have all the equipment required to provide the level of care documented in the care plans. The building has a current building warrant of fitness that expires on 6 July 2022. There is a maintenance staff member available on call for facility matters. Planned and reactive maintenance systems are in place. All electrical equipment has been tested and tagged. Clinical equipment has had functional checks/calibration annually.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of toilets and showers in the units, which are located close to residents' rooms. Residents said the facilities are appropriate for their needs and that privacy is maintained. There are separate toilet facilities for staff and visitors use. Water temperature recordings were sighted that recorded temperatures within safe parameters.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	There is adequate personal space provided in bedrooms which allow residents and staff to move around within the room safely. Residents interviewed spoke positively about their rooms. Mobility equipment was sighted in rooms of residents requiring this, with sufficient space for both the equipment, staff, and the resident. Rooms are personalised with furnishings, photos and other personal decorations. The service encourages residents to make the space their own. Residents' rooms were observed to be private. Some residents also have their own televisions. The dementia wing has a total of 15 beds. Initially on opening, the DHB had approved a maximum of 13 dementia level residents. The thirteen residents can and have occupied any of the 15 beds. All fifteen beds

		were assessed as part of this audit as being suitable for dementia level care.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas in each of the units include spacious open plan lounge and dining areas and space for visitors. There are open areas available for residents to use for recreational activities. Residents and family/whanau interviewed said the facility were suitable for them and that visitors were encouraged and felt comfortable. The dementia unit is secure and has good outdoor/indoor flow with areas to wander.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	The services policies and procedures provide guidelines regarding the safe and efficient use of laundry services. There is a dedicated housekeeping staff member. The cleaning chemicals are kept in designated locked cupboards. Laundry is completed by staff or by residents with staff support where able. There is one small laundry for domestic use and a larger laundry, off the dementia unit with a commercial washer and dryer. Residents interviewed reported satisfaction with the cleaning and laundry service. Internal audits monitor the effectiveness of the cleaning and laundry processes.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	The current health emergency plan is as per requirements for Covid-19 that has been audited by DHB and meets all requirements for any other infectious situation. The emergency procedure flipcharts cover all civil defence and emergencies. An approved fire evacuation plan is available. Fire equipment was tested. The orientation programme and education and training programme includes fire and security training. Staff interviewed confirmed their understanding of emergency procedures. A fire evacuation drill occurred in March 2021. A call bell system is in use. Staff have first aid training. External lighting and security systems, the building is alarmed and monitored. There are sufficient supplies for emergencies including food, water, and alternative cooking facilities.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with	FA	All residents bed and communal rooms have windows that can be opened. Heat pumps provide regulated temperatures. Residents conveyed being satisfied with the temperatures throughout the facilities in summer and winter. During the audit, the temperatures were pleasant.

adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.		
Standard 3.1: Infection control management 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.	FA	St Clair Park have a suite policies and procedures in place which reflect current best practice. Surveillance reports are collated and analysed on a monthly basis and there is a monthly report written. An annual review of the infection control programme has been completed (last completed 4 January 2021). A registered nurse undertakes the role of IPC coordinator. Infection control is discussed at meetings and there are weekly management discussions with the registered nurses. The facility has access to the DHB infection control specialist for advice. There have been no outbreaks since the previous audit. Outbreak management, isolation or segregation policy. There is a pandemic plan and pandemic trolley set up ready if required. There is plentiful supply of PPE and hand sanitisers.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator has completed external IC training and has external support from the local laboratory infection control team and IC nurse specialist at the DHB. There are adequate hand gels and hand washing facilities available.
Standard 3.3: Policies and procedures 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	FA	The infection control online manual outlines a comprehensive range of policies, standards and guidelines and includes roles, responsibilities, procedures, and training and education of staff. The policies were completed by an aged care consultant and reflects current good practice. All policies and documents have been updated in line with covid-19 requirements.

and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control policy states that the facility is committed to the ongoing education of staff and residents. Hand hygiene competencies are completed annually. Infection control education for staff has occurred in 2020 and was last completed June 2021. The infection control coordinator has completed some infection control training through Ministry of Health. Online education is available to staff. There are clear Covid signing in processes. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. Monthly infection data is collected and reported monthly by unit for all infections. These are based around antibiotic prescribing rather than signs and symptoms of infection. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at quality and staff meetings. Short-term care plans are used. Infections overall have been reported as low.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	Restraint minimisation policies and procedures include definitions, processes and use of restraints and enablers. St Clair Park is restraint free. On the day of audit, there were no residents with restraints or enablers. Staff training is provided on restraint minimisation and the management of challenging behaviour, which begins during their induction to the service and continues annually. Interviews with staff confirmed their understanding of how to safely remain restraint-free. The facility manager reported that plans are in place to provide staff with crisis prevention and intervention (CPI) training in the near future.

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)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Quality improvement data is collected electronically on the HCSL system (e.g., adverse events, infections, complaints) and also in hard copy (internal audit schedule and audits, resident satisfaction surveys). Adverse event data, and infections are collated and analysed with trends identified (if any). Missing was evidence of a consistent internal audit programme being completed as per the schedule and evidence that that staff are kept informed in meeting minutes of quality results (e.g., internal audit results/corrective actions, resident survey results).	i) The internal audit programme has not consistently been completed as per the audit schedule. ii) Complaints, resident survey results, and corrective actions are not consistently documented in the meeting minutes to evidence staff are kept informed.	i) Ensure the internal audit programme is completed as planned. with quality results communicated to staff. ii) Ensure that documented evidence indicates staff are kept informed regarding corrective

				actions required. 90 days
Criterion 1.2.5.1 The service demonstrates consumer participation in the planning, implementation, monitoring, and evaluation of service delivery.	PA Low	There is a current client participation policy that is not fully implemented. Residents provide feedback at monthly resident meetings and verbally to staff and the facility manager. A resident satisfaction survey has recently been completed. The service does not have a consumer advisor or representative as per policy. Staff identified as having lived experience from a consumer's perspective. The service does not demonstrate that residents participate at all levels of service delivery as per policy, however they have tried very hard to meet the requirements of this standard.	Residents do not have input at all levels of service delivery as per policy.	Ensure residents have participation in planning, implementation, and monitoring of service delivery. 90 days

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

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

No data to display

End of the report.