

Heritage Lifecare (BPA) Limited - Redroofs Rest Home

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:

Legal entity: Heritage Lifecare (BPA) Limited

Premises audited: Redroofs Rest Home

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 1 February 2022 End date: 2 February 2022

Proposed changes to current services (if any): None

Total beds occupied across all premises included in the audit on the first day of the audit: 48

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
Yellow	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
Red	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

Redroofs Lifecare provides rest home care for up to 50 residents. The service is operated by Heritage Lifecare Limited and managed by a care home manager and a clinical services manager. Residents and families spoke positively about the care provided.

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

Strengths of the service included treating residents with respect, the development of a vegetable garden, and a well-maintained environment.

Improvements are required in relation to:

- ensuring the 2022 business plan is developed and the 2021 business plan is reviewed
- ensuring all policies are current and developing an employment policy
- consistently ensuring the cleaning schedule evidences areas have been cleaned
- ensuring long term care plans are developed within the three-week required time frame

- ensuring the safe self-administration of medications
- ensuring goggles and face shields are cleaned and sanitised after use.

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 families 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. Personal privacy, gender, independence, individuality and dignity are supported. Staff interact with residents in a respectful manner.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

Residents who identify as Māori are able 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 resident’s 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.		Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.
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The 2021 Business and quality and risk management plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services provided to the governing body is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, identifies trends and leads to improvements. Staff are involved and feedback is sought from residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated.

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

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

Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred 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 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

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The facility meets the needs of residents and was clean and well maintained. There is a current building warrant of fitness. Electrical equipment is tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide shade and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen, and equipment are safely stored. Residents' personal belongings are laundered onsite. Linen is laundered offsite.

Staff are trained in emergency procedures, use of emergency equipment and supplies. Residents reported a timely staff response to call bells. Security is maintained.

Restraint minimisation and safe practice

<p>Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.</p>		<p>Standards applicable to this service fully attained.</p>
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The organisation has implemented policies and procedures that support the minimisation of restraint. There were no enablers and no restraints in use at the time of audit.

Staff were aware that any use of enablers is voluntary and for the safety of the resident. Those 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.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed from the general practitioner and the organisation's head office 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 reported through all levels of the organisation. 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)
Standards	0	39	0	3	3	0	0
Criteria	0	87	0	3	3	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Redroofs Rest Home has policies, procedures and processes (see 1.2.3.4) to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records (29 March 2021).</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>	FA	<p>Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. Additional consents were sighted for COVID-19 vaccinations. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day to day care.</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>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Meeting minutes showed that a representative from the Advocacy Service had spoken at a residents' meeting.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, shopping trips, activities, and entertainment.</p> <p>The facility currently has restricted visiting hours under the red traffic light system. Family members interviewed stated they felt welcome when they visited and comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaint forms, information on how to make a complaint, and a complaints box are at reception.</p> <p>The complaints register reviewed showed that five complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented, and completed within the timeframes. Action plans showed any required follow up and improvements have been made where possible.</p> <p>The care home manager is responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p>	FA	<p>Residents interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through the admission information provided and discussion with staff. The Code is displayed in the reception area and outside</p>

Consumers are informed of their rights.		the nurses' station, together with information on advocacy services, how to make a complaint and feedback forms.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit. All residents have a private room. There is one married couple who share a room.</p> <p>Residents are encouraged to maintain their independence by attending community activities, participation in clubs of their choosing. Care plans included documentation related to the resident's abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff 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.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff can support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day to day practice. The Māori Model of Care 'Te Whare Tapa Wha' guides staff in holistic care for Māori residents, though there were none at the time of audit</p> <p>Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Residents and their whānau interviewed reported that staff acknowledge and respected their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed, such as meal preferences, what activities they wished to attend, and interventions for medical conditions as required. The resident satisfaction survey confirmed that individual needs are being met.</p>

<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The orientation for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have completed the required 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 (see 1.2.3.4), input from external specialist services and allied health professionals, for example, speech language therapist, and education of staff. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to medical requests.</p> <p>Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.</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 members 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. 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>Staff knew how to access interpreter services, although reported this has not been required due to the use of family members, and most residents able to speak English.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	PA Low	<p>The 2021 business plan outlining the purpose, values, scope, direction, and goals of the organisation was sighted. The document described annual and longer-term objectives, the associated operational plans, and the review of the 2020 goals. The 2022 business plan has not been developed. The review of the 2021 goals has not taken place.</p> <p>A sample of monthly reports to the regional manager showed adequate information to monitor performance is reported including occupancy rates, complaints, financial</p>

		<p>performance, emerging risks, and issues.</p> <p>The service is managed by a care home manager who holds relevant clinical and management qualifications and has been in the role for six months. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The care home manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing learning.</p> <p>The service holds contracts with SDHB to provide rest home level care under an aged related residential care contract. Forty-eight residents were receiving services under the contract at the time of audit.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	<p>When the care home manager is absent, the clinical services manager carries out all the required duties under delegated authority. Support is provided by the clinical staff and the regional manager. Staff reported the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Moderate	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes, for example, management of incidents and complaints, audit activities, a regular resident satisfaction survey, education, monitoring of outcomes, clinical incidents including infections, and wounds.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the registered nurses' team meetings quality and risk team meetings and staff meetings. Meeting minutes were sighted. The care manager completes the electronic quality indicators template each month which is forwarded to head office. Staff reported their involvement in quality and risk management activities through, for example, audit activities and health and safety processes. Residents and families contribute to quality improvement through regular feedback and meetings.</p> <p>Relevant corrective actions are developed and implemented to address any shortfalls. Residents' satisfaction surveys are completed annually. The most recent survey was benchmarked with other Heritage Lifecare Limited facilities and showed a good result.</p> <p>Internal audits completed over the last 12 months included hand hygiene, hot water temperatures, and workplace inspections. Samples were sighted. The 2022 internal audit</p>

		<p>schedule was sighted.</p> <p>The document control system is managed by the national office. The service has not ensured all policies and procedures are current. The service was not able to provide an employment policy. Refer 1.2.3.4</p> <p>The care home manager described the processes for the identification, monitoring, review and reporting of risks and development of mitigation strategies. The risk register was sighted. The manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse and near miss events on an accident/incident form. A sample of four incidents forms reviewed showed these were fully completed, incidents were investigated, action plans developed and actions followed-up in a timely manner and signed off by the clinical services manager. Adverse event data is collated, analysed and reported to the regional manager.</p> <p>The clinical services manager described essential notification reporting requirements. The care home manager reported that no notifications of significant events have been made to the Ministry of Health since the previous audit. The clinical services manager confirmed this.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>The recruitment process includes referee checks, police vetting and validation of qualifications and annual practising certificates (APCs), where required. A sample of seven staff records reviewed confirmed the organisation's procedures are being consistently implemented and records are maintained. The care home manager reported that all the new employee's information is loaded into the electronic system, including 'time target'.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff are buddied with a senior caregiver and reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a six-week period.</p> <p>Continuing education is planned on an annual basis, including mandatory training requirements. The 2022 schedule was sighted. Care staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider's agreement with the DHB.</p>

		<p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.</p> <p>APCs were sighted for the physiotherapist, pharmacist, dietitian, and general practitioner. The service was not able to provide an employment policy. (refer 1.2.3.4).</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>	FA	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, 7 days a week (24/7). The electronic "Safe Rostering Tool" is used.</p> <p>The facility adjusts staffing levels to meet the changing needs of residents. Staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this.</p> <p>An afterhours on call roster was sighted that provides 24/7 RN coverage. The care home manager reported that the afterhours phone system is working well 24/7. A mobile phone has been purchased to provide additional phone resources.</p> <p>A review of a four-week roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.</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>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 into the Momentum electronic database. 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. Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in</p>	FA	<p>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.</p>

<p>a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>		<p>Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the NASC and general practitioner (GP) for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHBs 'yellow envelope' system to facilitate transfer of residents to and from acute care services. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. An example reviewed of a patient recently transferred to the local acute care facility showed appropriate documentation. Family of the resident reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>PA Moderate</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided on request.</p> <p>Controlled drugs are 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.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed</p>

		<p>were within the recommended range.</p> <p>Prescribing practices included the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded on the medicine chart.</p> <p>There are three residents who were self-administering some of their medications at the time of audit. One an inhaler, one a medicated spray and one resident has requested her early morning medication be left the night before as she does not like to be disturbed. Related processes were not being effectively managed.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. In the year 2021 there were a significant number of medication errors mainly relating to missed doses and not completing the outcomes of PRN medication. The clinical manager, since taking up the role six months ago, has worked with staff and in the last six months there has been a reduction in errors by fifty percent.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service is provided on site by two qualified chefs and a kitchen team and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years (for review in May 2022). Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Dunedin City Council which is current until 31 March 2022. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. All kitchen staff have relevant training certificates.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. If residents are hungry there are snacks available. Special equipment, to meet residents' nutritional needs, was available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had</p>

		this provided.
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	A file is kept of all enquires but the care home manager confirmed that no one has been declined entry. 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. There is a clause in the access agreement related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, and nutritional screening, as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed and the relevant outcome scores have supported care plan goals and interventions. Residents and families confirmed their involvement in the assessment process.
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>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.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. Medical notes are documented in the electronic system, so the GP has access when offsite. These are printed off to keep in the residents' files. Any change in care required is documented and verbally passed on to relevant staff. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	Documentation, 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 GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is of a high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was

		available, suited to the level of care provided and in accordance with the residents' needs.
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>The activities programme is provided by a trained diversional therapist (DT) holding the national Certificate in Diversional Therapy, volunteers, and a caregiver who is just commencing training to support the role. The DT works Monday to Thursday, the caregiver provides activities on Friday, and at the weekend some of the residents initiate activities and puzzles and movies are left out. The DT also arranges for some entertainers to come during the weekend.</p> <p>A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated on engagement at the time and as part of the formal six monthly care plan review. Attendance records are kept and a schedule for van outings maintained to ensure all residents have an opportunity to participate.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme stimulating and interesting. Residents were observed actively engaged in an exercise class on the day of audit.</p> <p>Those residents who are diagnosed with dementia have a plan describing behaviour management and individualised activities reflecting former routines covering the 24 hour period.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Training on the 'stop and watch' tool has been provided but not evidenced as being used. The shifts that are run by senior care staff always notify the on call person with any changes in a resident's condition.</p> <p>Formal care plan evaluations occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for wounds. When necessary, and for unresolved problems, long</p>

		term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	Residents are supported to access or seek referral to other health and/or disability service providers. The service has a 'house doctor' who sees all residents and visits the facility twice a week and as required. If the need for non-urgent services is indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to a speech language therapist. 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 accident and emergency in an ambulance if the circumstances dictate.
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	PA Moderate	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals, cleaning products, and relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew how to refill containers without any chemical spill/event occurring.</p> <p>There is provision and availability of protective clothing and equipment. Staff were observed using disposable gloves, hand sanitiser and face masks. Staff reported that eye protection and face shields are not appropriately cleaned and sanitised after each use.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building warrant of fitness expires on 2 March 2022.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment was current as confirmed in documentation reviewed, interviews with maintenance personnel, and care home manager, and observation of the environment. The environment was hazard free, residents were safe, and independence is promoted.</p> <p>External areas are accessible, safe, and provided shade and seating, and meet the needs of the residents. The maintenance staff described the maintenance schedule. The schedule was sighted.</p> <p>Residents confirmed they know the processes they should follow if any repairs or</p>

		<p>maintenance is required, any requests are appropriately actioned and that they were happy with the environment.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes facilities for staff and visitors. Two bedrooms have ensembles. Two bedrooms have toilet and handwashing facilities.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower areas, and other equipment/accessories are available to promote residents' independence. Three hot water temperature audits were sighted and all met the required standard. Residents and families reported they were happy with the bathroom facilities.</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. Two bedrooms provide shared accommodation. Where rooms are shared approval has been sought. Rooms are personalised with furnishings, photos and other personal items displayed.</p> <p>There is room to store mobility aids, wheelchairs and mobility scooters. Staff and residents reported the adequacy of bedrooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities, and this was witnessed on both days of the audit. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy, if required. Furniture and furnishings are appropriate to the setting and residents' needs. Residents and families reported they were happy with the environment.</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>	PA Low	<p>Linen is taken off site by a contracted provider for laundering. Residents' personal items are laundered on site in a dedicated laundry. The laundry was sighted. Dedicated laundry staff demonstrated a sound knowledge of the laundry processes, dirty/clean flow and handling of linen. Residents interviewed reported the laundry is managed well and their clothes are returned in a timely manner.</p> <p>There is a small, designated cleaning and laundry team who have received appropriate training. Chemicals were stored in a lockable cupboard and were in appropriately labelled</p>

		<p>containers.</p> <p>The documentation on the daily cleaning schedules did not evidence that all tasks had been consistently completed.</p> <p>One of two cleaning staff interviewed described the hygienic cleaning of the showers. Five of five showers sighted met the standard. The care home manager reported that one shower is on the Capex budget to be replaced.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Policies and guidelines for emergency planning, preparation and response are displayed and known to staff. Disaster and civil defence planning guides direct the facility in their preparation for disasters and described the procedures to be followed in the event of a fire or other emergency. Fire extinguishers, alarms, fire action plans, call boxes, floor plans with exits, hose reels, and sprinklers were sighted.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service (FENZ) on 19 January 2021. The most recent trial evacuation was held on 23 January 2020 with a copy sent to FENZ. The care home manager reported that due to COVID-19 trial evacuations have been suspended. The care home manager was in discussion with FENZ to hold a trial evacuation and staff training on 4 February 2022. Evidence of the emails was sighted.</p> <p>The orientation programme includes fire and security training. Staff interview and documentation confirmed this.</p> <p>Ongoing fire and emergency training is in place. Twenty-three residents and twenty-three employees attended fire training on 25 January 2022. Staff confirmed their awareness of the emergency procedures.</p> <p>Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, medical supplies, and gas BBQs were sighted and meet the requirements for the number of residents. The maintenance staff reported that a generator would be delivered if required. Emergency lighting is regularly tested.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and residents and families reported staff respond promptly to call bells.</p> <p>Appropriate security arrangements are in place. Windows have security stays and doors are alarmed. The care manager reported that night staff undertake security checks.</p> <p>Residents were happy with the emergency and security arrangements.</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. Rooms have natural light and opening external windows. Residents and families were happy with the environment, including ventilation, and privacy.</p> <p>Heating is provided by thermostatically controlled underfloor heating in residents' rooms. Heat pumps provide heat in the communal areas. A log burner provides heat in the lounge. Areas were warm and well ventilated throughout the audit and residents and families confirmed the facilities are maintained at a comfortable temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	<p>FA</p>	<p>The service implements 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 the organisation's head office. The infection control programme and manual are reviewed annually (January 2022).</p> <p>The clinical manager is the designated IC nurse, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the care home manager, and tabled at the quality committee meeting. The infection control committee includes the care home manager, IC nurse, a RN/EN and representatives from food services and household management. Information is reported to regional and national levels on a monthly basis.</p> <p>A QR code is available for scanning, a health declaration form, masks and sanitiser were at the main entrance to the facility. Family members are required to make a booking to visit relatives and are required to produce a vaccine certificate under the red traffic light system. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the</p>	<p>FA</p>	<p>The IC nurse has appropriate skills, knowledge and qualifications for the role, and has been in this role for six months. She is registered to attend online training in infection prevention. 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 IC nurse has access to residents' records and diagnostic results to ensure timely</p>

needs of the organisation.		<p>treatment and resolution of any infections.</p> <p>The IC nurse confirmed the availability of resources to support the programme and any outbreak of an infection.</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 last reviewed in 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 sanitiser dispensers were readily available around the facility. Staff interviewed verified 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 providers, support staff, and consumers.</p>	FA	<p>Interviews, observation and documentation verified staff have received education on infection prevention and control at orientation and ongoing education sessions. The IC nurse provides education. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an increase in infection incidence has occurred, there was evidence that additional staff education has been provided in response. An example of this occurred when several residents had eye infections.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and the information around COVID-19 restrictions.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, eye, gastro-intestinal, and the upper and lower respiratory tract. The IC nurse reviews all reported infections and these are documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that</p>

		<p>identify trends for the current year, and comparisons against previous years and this is reported to IC committee and regional quality manager. Data is benchmarked within the organisation. Benchmarking has provided assurance that infection rates in the facility are average for the sector.</p> <p>There have been no outbreaks 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 provide guidance on the safe use of both restraints and enablers. Forms for a register, assessment, monitoring, and review processes are included.</p> <p>The care home manager is the restraint coordinator and provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and her role and responsibilities.</p> <p>On the day of audit, there were no residents using either an enabler or a restraint. The care home manager reported that restraints and enablers have not been used for at least the last two years.</p> <p>Orientation and ongoing education included restraint minimisation and safe practice and managing challenging behaviours.</p> <p>The clinical services manager reported that a restraint and/or an enabler would be used as a last resort when all alternatives have been explored, for example, walking frames, sensor mats, low beds.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.1.1</p> <p>The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.</p>	PA Low	The 2021 business plan and the review of the 2020 goals was sighted. The care home manager reported that the organisation’s quality and risk managers meet nationally each year to discuss and develop the business plan. The regional manager then approves the plan. The meeting is due to take place in April 2022.	The 2022 business plan has not yet been developed. The review of the 2021 goals has not taken place.	<p>Provide evidence that the 2022 Business Plan has been developed, and that the 2021 goals have been reviewed.</p> <p>90 days</p>
<p>Criterion 1.2.3.4</p> <p>There is a document</p>	PA Moderate	Twelve percent (12%) of the policies and procedures were out of date. The provider was aware of this. The care home manager reported that head office was also aware and that the continuing review of the policies and	Twelve percent (12%) of policies and procedures	Provide evidence that the policies

<p>control system to manage the policies and procedures. This system shall ensure documents are approved, up to date, available to service providers and managed to preclude the use of obsolete documents.</p>		<p>procedures was planned.</p> <p>The provider was not able to provide an employment policy. The care manager reported that a checklist is available to ensure all requirements for the safe employment of an employee is met. The new employee's information is entered into the human resources electronic system. This allows 'time target' to generate the new employee on the roster and provides the template for the new employee to clock their hours of work in 'time target'.</p>	<p>were not current at the time of audit.</p> <p>The provider was not able to provide an employment policy.</p>	<p>and procedures are current.</p> <p>Provide evidence that an employment policy has been developed and implemented in accordance with good employment practice to meet the requirements of legislation.</p> <p>90 days</p>
<p>Criterion 1.3.12.5</p> <p>The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Moderate</p>	<p>Although the three residents administering their medications had been assessed as competent to do so, these assessments were not updated three monthly. It was not documented on the risk summary, in the long term care plan or noted on the electronic medication chart. There was no locked drawer in their rooms to secure medication in and, in the case of one resident, a PRN (as required) medication had not been prescribed by the general practitioner (this was rectified on the day of audit) so there was no record of the frequency that the medication was taken. This resident was interviewed and was competent, knew why they had the medication and when they should take it but did not let staff know when it was used, and said they did not take it very often.</p>	<p>The process of safe administration for three residents choosing to administer some of their own medications is not occurring according to the organisation's medication policy.</p>	<p>The policy for safe administration of medication by residents is implemented and documented.</p> <p>30 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service</p>	<p>PA Low</p>	<p>The files reviewed showed assessment, planning, provision, evaluation and review of long term care plans (LTCPs) was completed in detail.</p>	<p>Files reviewed showed care</p>	<p>All long term care plans are</p>

<p>provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>		<p>Personalised and specific medical needs were addressed and evidenced family/whānau input. InterRAI assessments were completed according to the contractual agreement, but LTCPs were not observed to be developed within the required three-week timeframe. Date of completions varied between four and nine weeks. This was observed in recent admissions' files as well as in older admissions' files.</p>	<p>planning was occurring, however none of the files reviewed had the long term care plan developed within the required time frame of three weeks. This varied between four and nine weeks.</p>	<p>developed within three weeks of admission. 90 days</p>
<p>Criterion 1.4.1.6 Protective equipment and clothing appropriate to the risks involved when handling waste or hazardous substances is provided and used by service providers.</p>	<p>PA Moderate</p>	<p>The Cleaning Schedule – Clinical informs that nursing staff are responsible for ensuring the clinical equipment is kept clean and hygienic. Staff reported that eye protection and face shields are not appropriately cleaned and sanitised after each use. The care home manager reported that reminders were in place to inform staff of the requirement.</p>	<p>Eye protection and face shields are not cleaned and sanitised after use.</p>	<p>Provide evidence that eye protection and face shields are cleaned and sanitised after each use. 60 days</p>
<p>Criterion 1.4.6.2 The methods, frequency, and materials used for cleaning and laundry processes are monitored for effectiveness.</p>	<p>PA Low</p>	<p>The daily cleaning schedule for the week beginning 24 January 2022 was sighted. Ticks were added to some tasks for 24, 25, 26 and 27 January. The column required initials. There was no documented evidence that cleaning had been completed for 28, 29 and 30 January. The column 'shift/position responsible' did not assign the responsibility. Initials were not entered on any examples sighted. A random selection of schedules was sighted, confirming the tasks are not consistently evidenced as being completed. Staff reported that the cleaning was done. This finding is rated low as the facility was observed to be clean.</p>	<p>The documentation on the daily cleaning schedules did not evidence that all tasks had been consistently completed.</p>	<p>Provide evidence that the documentation on the daily cleaning schedules is completed as required by the facility.</p>

				60 days
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Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.