

# Rosaria Rest Home 2006 Limited - Rosaria 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:

|   |   |
|---|---|
| <b>Legal entity:</b>  | Rosaria Rest Home 2006 Limited                      |
| <b>Premises audited:</b>  | Rosaria Rest Home                                   |
| <b>Services audited:</b>  | Rest home care (excluding dementia care)            |
| <b>Dates of audit:</b>  | Start date: 19 August 2019 End date: 20 August 2019 |
| <b>Proposed changes to current services (if any):</b>   | None  |
| <b>Total beds occupied across all premises included in the audit on the first day of the audit:</b> | 23  |

# 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

Rosaria Rest Home provides rest home level care for up to 26 residents. The service is operated by Rosaria Rest Home 2006 Limited and managed by the director/manager, an assistant manager and a registered nurse. 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 records, observations and interviews with residents, family members, managers and staff and a general practitioner. No interpreter was arranged specifically for this audit but the auditors managed as some residents interviewed and families spoke English.

The audit has resulted in areas requiring improvement relating to document control, the information provided to residents/family, medication competency and the dietitian review of the menu plans.

## 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. |
|--|--|--|

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. Services support personal privacy, independence, individuality and dignity. 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.

There is a Maori health plan to guide staff for residents who identify as Māori to ensure their needs are met in a manner that respects their cultural values and beliefs when needed. 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 low risk. |
|---|--|---|

Business, quality and risk management plans reviewed included the scope, direction, objectives and values of the organisation. Monitoring of the services is provided to the governing body regularly and effectively. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection of data and analysis. Any trends are identified which leads to quality improvement. Staff are involved and feedback mechanisms are in place. Adverse events are well documented with corrective

action plans implemented. Risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery.

The appointment of staff is based on current good practice. Full orientation is provided to new staff and ongoing training supports safe service provision and includes the completion of staff annual appraisals. Staffing levels and skill mix meet the changing needs of the residents.

Residents' records are documented in a timely manner, in accordance with current accepted standards and are stored securely.

## 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. |  | Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk. |
|--|--|--|

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

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

## Safe and appropriate environment

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

Rosaria Rest Home facilities meets the needs of residents and was well maintained, clean and tidy. There was a current building warrant of fitness and electric equipment is tested as required. Communal and individual spaces are maintained with appropriate heating at an even comfortable temperature. External areas are level and well maintained, with seating available. Shade is available in the summer months.

Waste and hazardous substances are well managed. Staff are protected with adequate supplies of personal protective equipment being available. Chemicals are stored safely. Laundry is contracted offsite and evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly. Residents reported a timely staff response to call bells. Security is maintained.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. No restraints were in use. Comprehensive documentation is maintained which includes assessment, approval, monitoring and review processes to be activated as needed. Staff interviewed demonstrated a sound knowledge and understanding of restraint minimisation and safe practice.

## Infection prevention and control

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

Standards applicable to this service fully attained.

The infection prevention and control programme is led by the registered nurse who is the infection control coordinator, and it aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required. There have been no infection outbreaks reported since the last audit.

## 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                           | 41                  | 0  | 3                                    | 1  | 0                                      | 0  |
| Criteria          | 0                           | 89                  | 0  | 3                                    | 1  | 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<br><br>Consumers receive services in accordance with consumer rights legislation.  | FA                | Rosaria Rest Home has developed policies, procedures and processes 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 sighted.   |
| Standard 1.1.10: Informed Consent<br><br>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA                | The registered nurse (RN) and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical records reviewed showed that informed consent had been gained appropriately using the organisation's standard consent form. Interviewed residents and family reported that the informed consent was discussed on admission using the language that the residents/family understood. The manager and the RN explain the informed consent with the residents and/family on admission. 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 records. Staff were observed to gain consent for day to day care. |

|  |    |   |
|--|----|---|
|  |    |   |
| <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 interviewed were aware of the Advocacy Service, how to access this and their right to have support persons. The RN provided examples of when they would involve Advocacy Services.</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 has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and comfortable in their 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 and compliments forms and associated documents meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is placed around the facility. Those interviewed, residents and family, knew how to make a complaint and to give compliments.</p> <p>The complaints register reviewed showed that two verbal and four written complaints have been received since the previous audit and that actions were taken through to an agreed resolution and documented processes were completed within the timeframes required. Action plans showed any required actions or improvements that have been made where possible. The manager is responsible for complaints management and any follow-up. All staff interviewed confirmed an understanding of the complaint process and what actions are required.</p> <p>There has been one complaint received from the DHB since the previous audit 2018 and this complaint was unsubstantiated and was effectively closed out.</p> |
| <p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their</p>  | FA | <p>Residents and family interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) as part of the admission information provided and discussion with the RN on admission. The Code is displayed on notice boards together with information on advocacy services in a language that is understood by the residents.</p>  |

|  |    |   |
|--|----|---|
| rights.  |    | The code is available in Chinese and English languages. Information on how to make a complaint and feedback forms are displayed in the front entrance foyer of the facility.  |
| <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, or share a room with their spouse, with their consent.</p> <p>Residents are encouraged to maintain their independence by participation in community activities of their own choice and in personal care tasks as desired. 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>On the days of the audit, there were no residents who identified as Māori. There is a Māori health plan in place to guide staff when required. Guidance on tikanga best practice is available. Interviewed staff were aware of the principles of the Treaty of Waitangi and the importance of family/whanau involvement in providing support for residents who identify as Maori.</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. Residents' personal preferences, required interventions and special needs were included in care plans reviewed. All residents on the days of the audit identified as Chinese and their different dialects were documented in the long-term care plans reviewed. The resident satisfaction survey confirmed that individual needs were being met.</p>   |
| Standard 1.1.7: Discrimination   | FA | Residents and family members interviewed stated that residents were free from any type of   |

|  |    |   |
|--|----|---|
| Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.  |    | discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. The registered nurse has records of completion of 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.  |
| Standard 1.1.8: Good Practice<br>Consumers receive services of an appropriate standard.  | FA | <p>The service encourages and promotes good practice through evidence -based policies, input from external specialist services and allied health professionals, for example, wound care specialist, psycho-geriatrician and mental health services for older persons, 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 through the local district health board (DHB) and access their own professional networks to support contemporary good practice.</p>  |
| Standard 1.1.9: Communication<br>Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | <p>Residents and family members stated they were kept well informed about any changes to their/their relative's health status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was supported 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 know how to access interpreter services, although reported this was rarely required due to all residents able to speak Chinese, staff able to provide interpretation as and when needed and the use of family members. On the days of the audit, interpretation was provided by family members for four residents who were interviewed and one resident could speak English well.</p> |
| Standard 1.2.1: Governance<br>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | <p>The strategic business/quality plan is reviewed annually and outlines the purpose, values, scope and direction of the organisation. The documents reviewed described annual objectives and the associated operational plans. The mission statement and philosophy of the organisation was displayed in the entrance to the facility. The manager is the owner/director of the service. The manager was able to evidence adequate information on how performance was monitored and reports included any emerging risks or issues raised.</p> <p>The facility manager interviewed is experienced in the aged care residential care sector and has</p>  |

|  |        |  |
|--|--------|--|
|  |        | <p>owned this facility since 2006. The manager confirmed knowledge of the sector, regulatory and reporting requirements. The facility manager upskills and attends training and meetings with other like services on a regular basis. The manager is also a current member of an aged care association ensuring any changes or information about the sector is known. The manager is supported by an assistant manager as required.</p> <p>The service holds contracts with the DHB for rest home and respite care. At the time of the audit there are 22 rest home residents and one boarder. No residents were receiving respite care.</p>   |
| <p><b>Standard 1.2.2: Service Management</b></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 facility manager is absent there is an assistant manager who can cover the business management aspects of the service and the registered nurse is available to cover all clinical aspects of service delivery. During absence of the registered nurse (RN), a senior RN (casual) is available to cover the RN. The RN cover is provided 24 hours a day seven days a week. Staff interviewed reported that the current arrangements work well.</p>  |
| <p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>                         | PA Low | <p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities (the audit schedule and results of audits were followed through), satisfaction surveys, monitoring of outcomes and clinical incidents including infections and restraint minimisation and safe practice.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly quality/staff meetings. Staff reported involvement in quality and risk activities through audits. Any relevant corrective actions are developed and implemented to address any shortfalls.</p> <p>The organisation acknowledges the Health and Safety at Work Act 2015 and ensures all requirements are met and they adhere to safety procedures and practices as set out by the organisation. Employees are required to conduct themselves in a manner that avoids harm to themselves and others. The service promotes health and safety measures to provide a safe environment for residents, staff and visitors to this facility. The manager maintains and monitors a safety programme and provides health and safety information about any hazards present in the work place, including the identification and control of these hazards. Health and safety is on the agenda for all meetings and this was reviewed.</p> <p>Resident, family and staff satisfaction surveys are completed annually. The results of the surveys were reviewed and positive comments evidenced that residents and families were satisfied with all</p> |

|   |    |  |
|---|----|--|
|   |    | <p>services provided.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are developed by an external quality consultant. The consultant advises if any changes are made to policies or new policies are introduced for implementation and these are placed in one folder not in the actual manual where applicable. The document control system evidenced that policies and procedures when updated were not replaced in the appropriate manuals. Any updated policies were kept in one folder sighted. Some policies reviewed had outdated referencing and dates had not been changed to verify the documents were current and up-to-date. Duplication of policies was evident in the manuals reviewed. The manager had been documenting that all policies were reviewed annually.</p> <p>The facility manager described the processes for identification, monitoring, review and reporting of risks and development of mitigation strategies.</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 events and near miss events on an accident/incident form. A sample of incident forms reviewed evidenced these were fully completed, incidents were investigated, action plans developed, and actions were followed up by the RN in a timely manner. Adverse event data is collated by the RN and reported to the manager. The RN maintains the 'accident/incident report folder'. This is well maintained. Any residents who have unwitnessed falls have neurological observations completed post fall. After the incidents and accidents are analysed monthly, the RN develops graphs which are used to report information to staff. Summaries and comparisons with the previous month occur.</p> <p>The RN is fully informed of what incidents/events require notification to the Ministry of Health, HealthCERT, Public Health or other agencies. There have been no Section 31 notices completed since the previous audit.</p>   |
| <p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>   | FA | <p>Human resource management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. All APCs were validated and records were maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Job descriptions were sighted. Staff records reviewed showed documentation of completed orientation and a performance</p>  |

|  |    |   |
|--|----|---|
|  |    | <p>review is completed annually. Staff interviewed (the RN, cook and caregivers), stated they all received at commencement of employment a full orientation and a buddy system was adopted until they felt comfortable in their designated role. All staff have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the service provider's agreement with the DHB.</p> <p>The one registered nurse maintains the annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training. The manager completes the annual performance appraisals.</p> <p>All care staff and the RN have completed current first aide and basic life support cardio-pulmonary resuscitation. Certificates were sighted in the records reviewed.</p> <p>The registered nurse is employed full time with time allocated to complete the interRAI assessments at three weeks after a resident is admitted and six monthly thereafter. The education programme developed and implemented covers the educational and contractual requirements for all staff.</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 provision, 24 hours a day seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. The registered nurse covers the after-hours for all clinical issues and the manager for non-clinical as required. The general practitioner interviewed is also on call after hours. The care staff interviewed reported there were adequate staff available to complete the work allocated to them and teamwork was promoted. The residents and staff interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided. Casual staff are available including an RN as needed. Staff are replaced as required for sickness and leave as needed. At least one staff member is on duty who has a current first aid certificate each shift.</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' file reviewed. Clinical notes were current and integrated</p> <p>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. Current residents' records were kept securely in the nurses' station and electronic records can only be accessed via individual passwords.</p>  |

|   |             |  |
|---|-------------|--|
|   |             | <p>Archived records are held securely on site and are readily retrievable using a cataloguing system. Residents' files are held for the required period before being destroyed.</p> <p>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 a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p> | PA Low      | <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. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with information about the service and the admission process. The organisation seeks updated information from NASC and GP for residents accessing services. A record of all inquiries is maintained by the manager and follow up is completed as required.</p> <p>Interviewed family members stated that they were satisfied with the admission process and the information that had been made available to them on admission. Residents' files reviewed contained completed demographic detail, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p> <p>An improvement is required to ensure that the service brochure has updated information on services provided.</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>                            | FA          | <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's '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. 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. Interviewed family of a resident who was transferred to acute care service reported being kept well informed during the transfer of their relative. A record is kept for all discharges and transfers to other providers with reasons for the transfer documented.</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</p>  | PA Moderate | <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 paper-based system was observed on the days of audit. The staff interviewed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. A caregiver was</p>  |



|   |               |   |
|---|---------------|---|
| <p>and safe practice guidelines.</p>  |               | <p>observed administering medication and appropriate procedures were followed.</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, as required. There were no controlled drugs on site on the days of the audit.</p> <p>Records of temperatures for the medicine fridge were documented and within the recommended range. There was no food or drinks in the medication fridge. No vaccines are kept on site.</p> <p>Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart. There were no standing orders.</p> <p>There were no residents who self-administer medicines at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner when required.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. An improvement is required in completing annual medication administration competencies for the RN.</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>PA Low</p> | <p>The food service is provided on site by the cook and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns. Culture appropriate meals are prepared</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 was issued by the ministry for primary industries. Food, freezer and fridge temperatures are monitored and recorded as part of the food control plan. The cook has undertaken a safe food handling qualification.</p> <p>A nutritional assessment is completed for each resident on admission to the facility and a dietary profile developed and a copy provided for the kitchen staff. If there are any changes, the kitchen staff is updated. On the days of the audit, the kitchen was clean and cleaning schedules were being completed. There were no expired food items in the pantry.</p> <p>Interviewed residents and family reported satisfaction with the food service. Satisfaction surveys and resident meeting minutes confirmed residents' satisfaction with the meal services. Residents were given enough time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p> |

|  |    |   |
|--|----|---|
|  |    | An improvement is required to ensure that the menu is reviewed in a timely manner.  |
| <p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p> | FA | <p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, information about other providers is given to ensure the prospective resident and family are supported to find appropriate care. The family and the prospective resident are informed of the reason for declining entry. The RN reported that if the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and family. There is a clause in the admission agreement related to when a resident's placement can be terminated.</p>  |
| <p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>   | FA | <p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, Braden scale, mini nutritional assessment and interRAI assessment, as a means to identify any deficits and residents' needs 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 by the interRAI trained RN on site. Interviewed residents and families confirmed their involvement in the assessment process.</p>  |
| <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>Care 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. Any change in care required is documented and verbally passed on to relevant staff. Observed shift handover confirmed adequate information is shared to promote continuity of service delivery. Interviewed 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</p>  | FA | <p>Documentation, observations and interviews verified the 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 implemented promptly. Care staff confirmed that care was provided as outlined in the</p>  |

|   |    |   |
|---|----|---|
| their assessed needs and desired outcomes.  |    | 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 the activities coordinator who has completed relevant external education. A weekly activities planner is posted on the notice boards and it is written in appropriate language for the residents and in English respectively.</p> <p>A social assessment and history are completed 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 as part of the formal six-monthly care plan review. Daily activities attendance is documented.</p> <p>Activities reflect residents' goals, ordinary patterns of life and include normal community activities. Individual, group activities and regular events are offered. Residents and family are involved in evaluating and improving the programme through satisfaction surveys. Interviewed residents confirmed satisfaction with the activities programme.</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 by the caregivers. If any change is noted, it is reported to the RN. Formal long-term 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 chest infections, wounds and urinary tract infections. The short-term care plans were closed off when acute conditions resolve. Unresolved acute problems are added to long term care plans. Interviewed residents and family confirmed being involved in evaluation of progress and any resulting changes.</p>   |
| <p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately</p>       | FA | <p>Residents are supported to access or seek referral to other health and/or disability service providers. If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files reviewed. The resident and the family 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>  |

|   |    |   |
|---|----|---|
| facilitated, or provided to meet consumer choice/needs.   |    |   |
| <p><b>Standard 1.4.1: Management Of Waste And Hazardous Substances</b></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> | FA | <p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Waste is collected by a contracted service provider. A large skip bin was evident in the corner of the property. Appropriate signage is displayed where necessary. The manager purchases all chemicals and cleaning products (four products only used) and provides relevant training for staff. Material data sheets were available where chemicals are stored and in the sluice room and staff interviewed knew what to do should any chemical spill event occur. A spill kit was available.</p> <p>There is provision and availability of personal protective clothing and equipment (PPE) and staff were observed using this. Storage for PPE was accessible and there were adequate stores available for replenishing the current stores visible and in use around the facility. Additional PPE stores of gloves, aprons and masks were available in the storeroom for emergency events.</p>   |
| <p><b>Standard 1.4.2: Facility Specifications</b></p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>   | FA | <p>A current building warrant of fitness is publicly displayed with an expiry dated 22 June 2020.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current and confirmed in documentation reviewed. On visual inspection, the internal and external environment is maintained. The external courtyard is a decked area. There are level pathways at the entrance to the facility. Residents are able to walk up the driveway to the street and can easily walk around the block safely without crossing any roads.</p> <p>The environment was hazard free and residents were safe with independence promoted.</p> <p>This aged care setting is appropriate to the resident group. All residents were mobile. Residents confirmed that they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. They were pleased with the environment. Repairs are 'closed off' when addressed by the manager and/or assistant manager or preferred providers as needed.</p> |
| <p><b>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</b></p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured</p>  | FA | <p>There are adequate numbers of accessible bathrooms and toilet facilities throughout the rest home. This includes two large showers one of which has been totally upgraded. Accessible toilets are close to residents' rooms. All three double rooms have their own toilet and hand basin. All single rooms have hand basins except for five that have their own toilet and hand basin. Staff toilets and visitor toilets are available and labelled appropriately.</p>   |

|  |    |  |
|--|----|--|
| privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.  |    |  |
| <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 | There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation except for three designated double rooms (couples only). Rooms were personalised with furnishings, photographs and other personal items on display.  |
| <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 | Communal areas are available for residents to engage in activities. The dining and lounge area is spacious and enables easy access for residents and staff. Residents can access areas for privacy. There is one other smaller lounge dining area that can be used for visitors and/or quiet times. The furniture in the lounges and dining room was appropriate to the setting and residents' needs.  |
| <p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>                     | FA | <p>Laundry is undertaken onsite. Residents' personal clothing is also done at the facility in the laundry provided. The laundry is small but functional. Staff are responsible for the laundry and cleaning seven days a week. Care staff interviewed demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen.</p> <p>There is one locked cupboard for cleaning materials, for example, glass cleaner. Chemicals are in refillable containers which are wall mounted and labelled. The cleaning trolley is stored when not in use. Staff have received chemical training provided by the manager (health and safety representative). Material data sheets were sighted.</p> <p>Residents and family interviewed reported their/their relatives personal clothes are managed effectively and returned in a timely manner. There are separate named baskets for each individual resident. When linen is folded and placed in the baskets these are given out by staff and put away in the residents' own rooms.</p> |
| Standard 1.4.7: Essential, Emergency, And Security Systems   | FA | Policies, procedures and guidelines for all emergency planning, preparation and response are accessible. Disaster and civil defence planning guides direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency.   |

|  |    |  |
|--|----|--|
| Consumers receive an appropriate and timely response during emergency and security situations.   |    | <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 3 October 2002. A fire evacuation drill takes place six monthly with a copy sent to the New Zealand Fire Service. Records were reviewed. A discussion with all staff was held post fire drill and this was documented and sighted. The last fire drill was recorded as the 27 February 2019. The orientation programme includes fire safety and security training. Staff interviewed 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, torches, PPE resources, mobile phones, linen and a gas barbecue were sighted and meet the requirements for the 22 residents and one boarder at this facility. Water storage (a tank) meets the requirements of the local council. There is no generator on site. Gas hot water heating is available throughout the facility. Emergency lighting is available. These resources are regularly tested and recordings were validated.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and resident and families reported staff respond in a timely manner. Call bells were observed in all service areas within the facility.</p> <p>Appropriate security arrangements were in place. Door and windows are locked at a predetermined time and the facility is checked by staff. Close circuit television cameras (CCTV) are evident around the facility in the communal areas. Residents and family are informed of camera surveillance and appropriate signage is available.</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> | FA | <p>All residents' rooms and communal areas are heated and ventilated appropriately. A heat pump is visible in the main lounge and dining area. Gas wall heaters are in the hallways and individual electric heaters are visible in resident's individual rooms in use. An even temperature is maintained. All bedrooms have an external window and natural light. Areas were warm and well ventilated during the audit and residents and families interviewed confirmed that the facility is maintained at a comfortable temperature. Blinds and curtains are at the windows.</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</p>               | FA | <p>The service has implemented an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual, with input from the local DHB as required. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse is the designated infection control coordinator (ICC), whose role and responsibilities are defined in a job description. Infection control matters, including surveillance</p>  |

|  |    |  |
|--|----|--|
| the size and scope of the service.   |    | <p>results, are reported monthly to the manager and in staff meetings.</p> <p>Signage at the main entrance to the facility requests anyone who is, or has been unwell with an infectious condition, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell with an infectious condition. There were no infection outbreaks reported since the last audit. Interviewed staff 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 needs of the organisation.</p>  | FA | <p>The ICC has appropriate skills and knowledge for the role and has been in this role for three years. The ICC has attended relevant study days, as verified in training records. Additional support and information are accessed from the infection control team at the local DHB, the community laboratory, the GP and public health unit, as required. The coordinator has access to residents' records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The ICC confirmed the availability of resources to support the programme and any outbreak of an infection when required. Infection control emergency supplies were sighted in the store room.</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 reflect the requirements of the infection prevention and control standard and current accepted good practice. Policies were last reviewed within the past year and include 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 are 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 in infection prevention and control at orientation and ongoing education sessions. Education is provided by the ICC. Content of the training is documented and evaluated to ensure it is relevant, current and understood. Education evaluation forms were sighted. A record of attendance was maintained. When there is an increase in infection incidents, there was evidence that additional staff education has been provided in response.</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 have an infectious condition and increasing fluids during hot weather.   |
| <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, wound infections, the upper and lower respiratory tract and eye infections. The ICC 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 identify trends for the current year and comparisons against previous years. This is reported to the manager.</p> <p>Internal infection control audits are conducted by the ICC and any identified needs are addressed appropriately. Internal audit records were sighted.</p> |
| <p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>  | FA | <p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is the RN who provides support and oversight for enabler and restraint management in the facility. The RN understood the organisation's policies, procedures and practice and the responsibilities of the role.</p> <p>On the day of the audit no restraints or enablers were in use. No restraint or enablers have been used for five years. Enablers, when in use, were the least restrictive and used voluntarily at the individual residents' request. Restraint is used as a last resort when all alternatives have been explored.</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)   |
|---|-------------------|---|--|--|
| Criterion 1.2.3.4<br>There is a document 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. | PA Low            | There is a document control system in place to manage policies and procedures. However the system only reflects documents that have been updated by the contracted quality consultant. Policies and procedures requiring annual and/or two yearly reviews are not currently recorded and the review dates are not documented to evidence currency. All policies are recorded in each manual reviewed as being reviewed annually by the manager. Duplication was evident in the manuals reviewed. The documents reviewed onsite at audit were not in the appropriate manuals when needing to be replaced. Changed documents were kept in one folder. The obsolete documents were not removed at the time the policy was changed. | The manager interviewed does not have clear understanding of documentation control requirements. The reviewed and amended policies and procedures were not replaced in the quality manuals reviewed. Obsolete policies and procedures were not removed and duplication of policies and procedures was evident. | Provide evidence that all hard copy policies and procedures and manuals for staff to access are current and up-to-date and that the current system is reviewed and maintained appropriately. |

|  |             |   |  |   |
|--|-------------|---|--|---|
|  |             |   |  | 180 days  |
| <p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p> | PA Low      | <p>Entry to services is facilitated by the manager. The RN is responsible for the admission process and documentation once admission criteria is met. Prospective residents are given the service brochure at inquiry stage. The service brochure for the service has outdated information on services provided.</p>  | <p>The service brochure has outdated and inadequate information about the services provided by the facility.</p>           | <p>Provide an updated service brochure with accurate information on the services provided by the service.</p> <p>180 days</p> |
| <p>Criterion 1.3.12.3</p> <p>Service providers responsible for medicine management are competent to perform the function for each stage they manage.</p>   | PA Moderate | <p>Medication reconciliation is completed by the RN fortnightly when medication packs are received from pharmacy. All caregivers who administer medication have current medication administration competencies. The RN is responsible for conducting the medication administration competencies for the caregivers. However, an improvement is required to ensure that the RN's medication administration competency is renewed annually as per current medication management guidelines.</p> | <p>The RN does not have current medication administration competency in place as per medication management guidelines.</p> | <p>Provide evidence that the RN's annual medication administration competency is completed.</p> <p>60 days</p>                |
| <p>Criterion 1.3.13.1</p> <p>Food, fluid, and nutritional needs of consumers are provided in line with recognised nutritional guidelines appropriate to the consumer group.</p>  | PA Low      | <p>Culturally specific meals are provided for the residents. Personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet residents' nutritional needs, is available. The menu in use was not reviewed by the dietitian in a timely manner.</p>   | <p>The menu has not been reviewed by the dietitian within the last two years.</p>  | <p>Ensure that the menu is reviewed in a timely manner.</p> <p>180 days</p>   |



## 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.