Elsdon Enterprises Limited - Annaliese Haven Rest Home

Introduction

This report records the results of a Partial Provisional Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by 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:	Elsdon Enterprises Limited
Premises audited:	Annaliese Haven Rest Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 30 July 2020 End date: 30 July 2020

Proposed changes to current services (if any): The service provider has applied to reconfigure services by converting 21 rest home beds to dual purpose hospital/rest home.

Total beds occupied across all premises included in the audit on the first day of the audit: 54

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. General overview of the audit

Annaliese Haven Rest Home comes under the auspices of Elsdon Enterprises Limited and provides rest home level care, including dementia rest home care, for up to 61 residents. The service provider has notified their intention to convert 21 of the rest home beds to dual purpose hospital/rest home beds, thus raising the need for a partial provisional audit. A recently employed facility manager and a clinical nurse manager are responsible for management of Annaliese Haven Rest Home. Residents informed they are well cared for and very comfortable living in this facility.

This partial provisional 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 and organisational records, review of staff files and residents' medicine records, observations and interviews with residents, managers, staff and one of the owners. Relatives were not interviewed and residents' records not reviewed due to it being a partial provisional audit.

One area requiring improvement was identified during the audit. This relates to monitoring records for aspects of the environment being absent or incomplete and overdue checks of some electrical equipment and of the calibration of bio-medical equipment.

Consumer rights

Not applicable

Organisational management

Business and quality and risk management plans included the scope, vision, motto and goals of the organisation. Monitoring of the services provided to the governing body was regular and effective.

An experienced and suitably qualified person manages the facility with support from a person with relevant clinical management skills.

The appointment, orientation and management of staff are 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 current residents. An overview of how the organisation proposes to manage staffing requirements when hospital level care is available has been developed. The recruitment of additional staff has commenced.

Continuum of service delivery

A safe system for managing medicines is in place. Medicine records are electronic and medicines are administered by staff who have completed a relevant medicine management competency.

The food service meets the nutritional needs of the residents with special needs and personal preferences catered for. A food control plan which assures food safety is in place.

Safe and appropriate environment

The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provide seating.

Waste and hazardous substances are managed according to documented processes. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and is monitored via the service provider's internal audit system.

Staff have been trained in emergency procedures and the use of emergency equipment and supplies. Fire evacuation procedures are regularly practised. Call bell systems are monitored and security is maintained.

Restraint minimisation and safe practice

Not applicable

Infection prevention and control

The infection prevention and control programme is aimed at preventing and managing infections. It is led by an infection control coordinator, includes monthly infection surveillance activity and is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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	14	0	1	0	0	0
Criteria	0	33	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The business plan, which is reviewed annually, outlines the Annaliese Haven's mission of 'providing the best care in a loving family atmosphere delivered by staff who are trained and chosen for their skills and empathy in helping others'. This sits alongside a vision statement. The business plan describes the industry, range of services, refers to the separate quality management plan, includes a full 'Strengths, Weaknesses, Opportunities and Threats' analysis and a describes a set of business objectives and values. Associated operational plans describe the inclusion of hospital level care from the facility. The facility manager is responsible for ongoing reporting of finances, operations, quality assurance issues and identified risks to representatives of the owners and board of Elsdon Enterprises. The service is managed by a facility manager who is supported by a clinical manager. Responsibilities and accountabilities for the facility manager role are defined in a signed job description and individual employment agreement. Review of the personnel file of the facility manager confirmed prior knowledge of the sector. This person has only been in the role for approximately three weeks and although they have not been connected to the aged care sector for some years, there was evidence of ongoing updates in relation to their management and leadership expertise. The owners and clinical nurse manager are currently

		supporting them in reorienting back to the aged care sector and ensuring they are familiar with, regulatory and reporting requirements. The service holds contracts with the District Health Board. All residents except one are receiving rest home services under the Aged Related Residential Care Agreement with 30 of these receiving dementia care. The one exception is a person receiving services via a special funding package related to psychiatric residential rehabilitation. In response to a DHB query, premium room charges are clearly detailed within the admission agreement, which as per contractual requirements are being signed by residents and/or their family/Enduring Power of Attorney at the time a resident is admitted. These specified premium charges have not necessarily been charged to the resident and recent requests that these be paid, as per the agreement. This has caused some people to believe there has been an increase in fees, which has not been the case. There has not been any increase in premium charges for existing residents. An interview with one of the owners of the facility, the new facility manager and the clinical nurse manager was undertaken to meet the requirements of the partial provisional audit. All stakeholders were familiar with the Code of Health and Disability Services Consumers' Rights, the Aged Related Residential Care Agreement requirements and the needs of people receiving rest home, including dementia care, and hospital level care. The organised business structure within Elsdon Enterprises Limited and the managers of the Annaliese Haven care facility are conversant with requirements. The impact of changing use of some of the current rest home beds for hospital care has been assessed and relevant people have been informed of their intention. There were no current legislative compliance issues that could affect the service.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During any absence of the facility manager, the clinical nurse manager is authorised to carry out specified duties under delegated authority. The owners of the facility are also available to assist in any unforeseen circumstances, as are managers from other aged care facilities of Elsdon Enterprises Limited. Staff confirmed there is a team of experienced registered nurses, with more currently undergoing orientation, who collectively take responsibility for any clinical issues that may arise during any absence of the clinical nurse manager. In

		addition, the staff have a good relationship with the local GP practice.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Human resources 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, which was confirmed by staff; however, some of the records for new staff interviews and referee checks over the past twelve months were not available in staff files. The new manager expressed an awareness of the need to retain such records. Staff orientation includes all necessary components relevant to the role. All except one staff person interviewed reported they had had a satisfactory orientation to their role. Staff records reviewed showed completed orientation documentation and a performance review after a three-month period. Annual performance appraisals are undertaken every twelve months; however, of the random section of staff files reviewed only one person had been with this service provider for more than 15 months. Continuing education is planned on an annual basis, including mandatory training requirements. Records reviewed demonstrated that regular in-service training that included at least two mandatory training topics ceased during the Covid-19 lockdown, although plans were in place to restart these in August and catch up on the requirements with staff. Self-directed learning packages have been developed to assist staff who miss an in-service session. Additional manual handling/hoist use training has already occurred and the clinical nurse manager reported that topics including pain management and management of the deteriorating patient have been added to the training schedule specifically to ensure staff are prepared for providing hospital level care. 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. All staff (20), including the registered nurses and the diversional therapists, who are regularly rostered to work in the dementia care area have either completed, or are enrolled in the required education. Three registered nurses, including the clinical nurse manager, have a current competency to undertake interRAI assessments.

Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week (24/7). The facility adjusts staffing levels to meet the changing needs of residents and ensures those trained in dementia care are allocated in the dementia service accordingly. An after-hours on call roster for registered nurses is in place, with staff reporting that good access to advice is available when needed. The facility manager and the clinical nurse manager are to share afterhours/on call management roles once the facility manager has completed her orientation with the owners. Staff interviewed informed that although it can get busy at times there are adequate staff rostered on duty. Observations and review of three previous weeks of the roster plus two ahead confirmed adequate staff cover is being provided. Relief staff had been brought in to cover unplanned staff absences. At present all staff except those recently employed, which the clinical nurse manager confirmed would not be left alone, have undergone first aid training. There is currently registered nurse cover in Annaliese Haven from 6.45 am until 11.00pm. A paper on proposed staffing for hospital level care was provided and demonstrated how the hospital will have registered nurse cover 24/7. This also showed how the rest home will be staffed to ensure hospital care residents receive the required level of care. The service provider currently has adequate part-time caregivers willing to work additional shifts for when hospital care provision commences and recruitment processes for additional registered nurses (RNs) are underway with two new RNs with aged care experience receiving orientation and one other commencing the week after the audit.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. Safe medicine management systems were observed and confirmed via records sighted during the audit. Medicine records sit within an electronic system, which is closely monitored by the clinical nurse manager. Staff demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. Only level four caregivers and registered nurses may undertake medicine administration competency and according to records of annual reviews sighted, all staff who administer medicines

		are competent to perform the function they manage. Medicines are supplied to the facility in a pre-packaged format from a contracted pharmacy. A registered nurse checks medications against the prescription and signs the packaging. Clinical pharmacist input is provided on request. Controlled drugs are stored securely in accordance with requirements. On the day of audit, the usual storage cupboard was broken and these medicines were stored in a locked metal safe attached to the wall of the medicine room. The controlled drug register provided evidence of two staff checking each controlled drug administration as well as weekly and six-monthly stock checks. The records of temperatures for the medicine fridge were within the recommended range. Prescribing practices are in accordance with the electronic system and included, for example, the identity of the prescriber, the date of the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines. The required three-monthly GP review was consistently recorded in the electronic records. Appropriate policies and procedures for self-administration of medicines were described and available. However, it was not possible to assess the safety of self-administration as there were no residents self-administering their medicines and staff informed that for safety reasons it was discouraged in this facility.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns with a four-week rotating menu. This has been reviewed by a qualified dietitian and there was evidence that the next review, which fell due during the Covid-19 national lockdown, has been scheduled. Kitchen staff advised that changes may be made in response to residents' preferences in which case an item may be replaced with one of a similar type. 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 control plan and the last registration was issued by the local Waimakariri District Council. As the latest reassessment was less than a week ago the formal updated documentation was not available; however, there was evidence that an 18-month timeframe has been granted before the next inspection is due. Food temperatures, including for high risk items, are monitored

		appropriately and recorded as part of the plan. Relevant safe food handling training has been undertaken by kitchen staff. A nutritional assessment is undertaken for each resident on their 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. Kitchen staff expressed confidence that they will manage the additional needs of hospital level residents and described avenues of actions open to them should that change. Residents in the dementia service have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs was available. Evidence of resident satisfaction with meals was verified by resident interviews and the cook informed that not only does she take time for one on one discussion with residents about the food, but she attends resident meeting minutes where meals are an agenda item. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	Staff follow documented processes for the management of a range of types of waste and infectious and hazardous substances. General waste and recyclable cardboard, is removed by a contractor on a regular basis. Other recycling is put out for removal via the local council collection process. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material safety data sheets were available where chemicals are stored, and staff interviewed knew what to do should any chemical spill/event occur. There is provision and availability of personal protective equipment including aprons, gloves, masks and a face shield and staff were observed using items as applicable.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are	PA Low	A current building warrant of fitness (20 July 2020) was publicly displayed. Appropriate systems were in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. Hot water temperatures

fit for their purpose.		checks in all residents' rooms and in service areas had been completed every two months. Temperatures of residents' rooms and of the communal areas had also been completed every two months. However, there was limited evidence to demonstrate that the maintenance checks are being completed as required as checklist records were incomplete. Records sighted also showed that testing and tagging of some electrical equipment were overdue and the calibration of various bio medical equipment was also not current. A complaint about a leak in a ceiling had been filed with the DHB. The managers confirmed during interview that they had not been aware of this leak until they heard from the DHB. They had not been informed about it and it had not appeared in the maintenance log or any maintenance monitoring record. A second leak was also found. These areas were checked during audit and were found to have been repaired satisfactorily. A refurbishment process starting in residents' rooms in the Ashley wing has commenced. To date, two rooms have been renovated and they appear fresh and modern. External areas are safely maintained and were appropriate to the resident group/s and setting. An enclosed courtyard with planting enables residents with dementia to wander around safely. Staff confirmed they know the processes they should follow if any repairs or maintenance are required and that requests are usually actioned. Residents interviewed were happy with what they described as a 'homely' environment.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. The configuration of such facilities varies with a mix of personal ensuites, some with toilets and hand basins only and some also having showers, shared bathrooms with a toilet and shower and separate toilets. Ensuites are attached to each bedroom in the Ashley Wing, where it is planned to have the dual care beds. Six of the 21 rooms have an ensuite with a toilet and hand basin only and have easy access to a shared toilet/shower bathroom. The remaining 15 rooms have a shower, toilet and hand basin (1.7metres by 1.6 metres). The shared bathroom is suitable for the use of a shower trolley should this be required. Appropriately secured and approved handrails are provided in the toilet/shower

		areas, and other equipment/accessories are available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. All bedrooms provide single accommodation. Rooms are personalised with furnishings, photos and other personal items displayed. They are of sufficient size for hospital level care residents with doors wide enough to manoeuvre wheelchairs and larger easy chairs through (90cm). The bedroom size of 3.5 metres by 4.5 metres (some are larger) in the Ashley Wing is where the service provider plans to have the dual-purpose rooms. There is room to store mobility aids and wheelchairs. Staff and residents reported the adequacy of bedrooms and were confident hospital level care could be easily provided within the rooms of the Ashley wing.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Communal areas are available for residents to engage in activities or to relax in. The dining and lounge areas are of adequate size and residents are currently able to easily mobilise around them. If there were a significant number of hospital level residents in larger chairs, then options such as two dining sessions may reportedly be considered. Residents can access other areas for privacy when required with small seating areas at the end of each wing and external courtyard areas. Furniture is appropriate to the setting and residents' needs. Several comfortable looking larger chairs suitable for hospital residents to relax in whilst still being easy for staff to manoeuvre were available and more were reported to being ordered.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	Policies and procedures on cleaning and laundry services are described within the quality management system. Additional information on cleaning and laundry services sits within the laundry and a cleaning task list is attached to each of the cleaning trolleys. Laundry is undertaken on site in a dedicated laundry. The laundry staff person interviewed, who also undertakes caregiving duties, demonstrated a sound knowledge of the laundry processes, dirty/clean flow within the laundry and about

		the handling of soiled linen. There are some concerns raised at times about residents not getting their own clothing back; however, when investigated these are usually the result of new clothing provided by family members that have not been labelled. Laundry is undertaken and returned within 24 hours. There is a small designated cleaning team. These staff undertake chemical management training provided through the chemical supplier. Chemicals were stored in the laundry in a lockable cupboard and were in appropriately labelled containers. All chemicals are dispensed in metred doses via relevant equipment. The cleaning equipment trollies were suitably arranged, and staff informed they are taught to manage them in ways that ensure there are no risks to residents, especially in the dementia service. Cleaning and laundry processes are monitored through the internal audit programme with results of the last one dated 22 April 2020. No corrective actions were required.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	Policies and guidelines for emergency planning, preparation and response were 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. The current fire evacuation plan was approved by the New Zealand Fire Service on the 10 November 2011. A trial evacuation takes place six-monthly with a copy sent to the New Zealand Fire Service, the most recent being on 21 February 2020. The orientation programme includes fire and security training. Staff confirmed their awareness of the emergency procedures. Adequate supplies for use in the event of a civil defence emergency, including food, water, blankets, mobile phones and gas BBQ's were sighted and meet the National Emergency Management Agency recommendations for the region. The maintenance person informed the service provider has a contract with a company to supply a generator should the electricity fail in an emergency. Emergency lighting is regularly tested alongside testing of fire and emergency equipment. Call bells alert staff to residents requiring assistance. Call system audits in every bedroom and communal room are completed three-monthly as part of the health and safety audit (last audit April 2020). Observations made during the audit showed staff responded promptly to call bells.

		Appropriate security arrangements were in place. Doors and windows are locked at a predetermined time depending on the season. There have been no security alerts of concern.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	All residents' rooms and communal areas are heated and ventilated appropriately. Rooms have natural light and opening external windows. Heating is provided by ceiling and wall mounted panel heaters in residents' rooms in the communal areas. The temperature of all rooms is checked every two months and records show these are consistently warm at around 21 to 23 degrees Celsius. Two residents informed they are never cold and appreciate the warmth of their room and the facility. Annaliese Haven is a Smokefree facility with no smoking inside or outside. One person goes onto the street at the front of the facility as they choose not to smoke in the designated staff smoking area.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.	FA	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 externally provided infection control manual, with input from a general practitioner, applicable expertise from the local District Health Board and/or from a microbiologist as and when required. The infection control programme and manual are reviewed annually with the last review of the programme completed January 2020. The clinical nurse manager is the designated IPC coordinator, whose role and responsibilities are defined in a job description. Infection control matters, including surveillance results, are reported monthly to the facility manager and are benchmarked against other similar facilities. Applicable processes have been instituted and relevant information provided to manage the potential risks associated with the current Covid-19 pandemic. Signage at the main entrance to the facility requests anyone who is, or has been unwell in the past 48 hours, not to enter the facility. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. The managers confirmed that staff understand these responsibilities and that they will be sent home if they arrive at work unwell.

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 1.4.2.1 All buildings, plant, and equipment comply with legislation.	PA Low	Systems are in place to ensure building and property maintenance is monitored and to ensure the safety of equipment and services. Not all of these systems were being upheld as required. The monthly maintenance checklist for 2020 was not available when requested and there was evidence that when produced later it had been completed retrospectively. Checks of some electrical equipment and calibration of the weighing scales and of medical equipment were overdue.	Records intended to monitor property end environmental maintenance were incomplete at the time of audit. Checks of electrical equipment and calibration of medical equipment were overdue.	Ensure maintenance monitoring records, electrical checks and the calibration of biomedical equipment are up to date and comply with legislation. 30 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.