

Heritage Lifecare Limited - Palms Lifecare

Introduction

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

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Palms Lifecare
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 June 2021 End date: 17 June 2021
Proposed changes to current services (if any):	None
Total beds occupied across all premises included in the audit on the first day of the audit:	108

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Palms Lifecare provides rest home and hospital level of care for up to 118 residents. The service is operated by Heritage Lifecare Limited (HLL) and is managed by an interim care home and village manager. An assistant care home manager and a clinical services manager are responsible for the clinical management of residents.

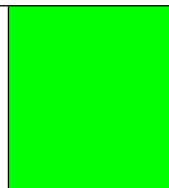
Authorisation was gained from HealthCERT since the previous audit to reduce one rest home level care resident's room, to turn this into an office which was verified and is now utilised by HLL management.

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

The audit resulted in two areas identified as requiring improvement in quality and risk management systems specific to documentation control and timeliness of review of policies and procedures.

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 are provided that 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.

Residents who identify as Māori have their needs met in a manner that respects their cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

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

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

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Business and quality and risk plans include the scope, direction, goals, values and mission statement of the organisation. Monitoring of the services, provided to the governing body, is regular and effective. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection and analysis of quality improvement data, any trends are identified and actions lead to improvements. Feedback is sought from staff, residents and families. Adverse events are documented with corrective actions implemented. Actual and potential risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery as needed.

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

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

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

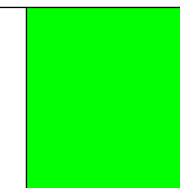
The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and 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 nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The facility meets the needs of residents and was clean and well maintained. There was a current building warrant of fitness. Electrical equipment has been tested as required. Communal and individual spaces are maintained at a comfortable temperature. External areas are accessible, safe and provided shading and seating.

Waste and hazardous substances are well managed. Staff use protective equipment and clothing. Chemicals, soiled linen and equipment are safely stored. Laundry is undertaken onsite and evaluated for effectiveness.

Staff are trained in emergency procedures, use of emergency equipment and supplies and attend regular fire drills. Fire evacuation procedures are regularly practised. Residents reported a timely response to call bells. Security is maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The organisation has implemented policies and procedures that support minimisation of restraint. Five enablers were in use at the time of the audit and three restraints. Use of enablers is voluntary for the safety of residents in response to individual requests. The restraint team meets six monthly to review the use of both enablers and restraints. Policy identified that assessment, approval and monitoring processes meet the restraint standard requirements. Staff interviewed demonstrated a sound knowledge and understanding of the restraint and enabler processes.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection prevention and control programme, led by an experienced and trained infection control coordinator, aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is accessed when needed.

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

Aged care specific infection surveillance is undertaken, and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	1	0	0	0
Criteria	0	100	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 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Palms Lifecare 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.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	Nursing and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's general consent forms. Advance care planning, establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Staff were observed to gain consent for day-to-day care.

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, residents are given a copy of the Code, which also includes information on the Advocacy Service. Posters and brochures related to the Advocacy Service were also displayed and available in the facility. Family members and residents spoken with were aware of the Advocacy Service, how to access this and their right to have support persons. Staff provided examples of the involvement of Advocacy Services in relation to staff training and resident information sessions.</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 events in the community.</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 policy and associated forms meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents and families on admission and those interviewed knew how to do so. Complaints forms are available at the entrance to the hospital and to the rest home. Complaints and compliments can also be placed in a locked complaints box at reception.</p> <p>The complaints register reviewed showed that 13 complaints had been received over the past year and that actions were taken through to an agreed resolution, were documented and completed within the required timeframes. One complaint which was closed out has been reopened and is being readdressed. Any quality improvements have been made where possible. The interim care home and village manager and the clinical services manager are responsible for complaints management and follow up. All staff interviewed confirmed a sound understanding of the complaint process and what actions are required.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents interviewed report 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 staff. The Code is displayed in common areas together with information on advocacy services, how to make a complaint and feedback forms.</p>

<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.</p> <p>Residents are encouraged to maintain their independence by attending community activities, arranging their own visits to the doctor and regular outings. Care plans included documentation related to the residents' abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and annually.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>Staff support residents in the service who identify as Māori to integrate their cultural values and beliefs. The principles of the Treaty of Waitangi are incorporated into day-to-day practice, as is the importance of whānau. There is a current Māori health plan developed with input from cultural advisers. Guidance on tikanga best practice is available and is supported by staff who identify as Māori in the facility. Māori residents and their whānau interviewed reported that staff acknowledges and respected their individual cultural needs.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences, required interventions and special needs were included in care plans reviewed. The resident satisfaction survey confirmed that individual needs are being met.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. The induction process for staff includes education related to professional boundaries, expected behaviours and the Code of Conduct. All registered nurses have 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</p>

other exploitation.		would follow, should they suspect any form of exploitation.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service encourages and promotes good practice through evidence-based policies, input from external specialist services and allied health professionals, for example, the hospice/palliative care team, diabetes nurse specialist, wound care specialist, psychogeriatrician 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. Staff reported they receive management support for external education and access their own professional networks to support contemporary good practice.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. This was 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. Staff know how to access interpreter services through the District Health Board (DHB), although reported this was rarely required because most residents can speak English and staff and family members are able to provide interpretation as and when needed.
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 strategic, quality and business plans, which are reviewed annually, outline the purpose, values, scope direction and goals of the organisation. Specific goals for this facility are also documented for 2021 and 2022. Five goals are set and are reviewed regularly for progress and achievement. A sample of monthly and quarterly reports to manager's support office includes the monitoring of performance outcomes, including quality data, staffing, complaints, quality improvements made, any emerging risks and issues. The service is managed by an interim care home and village manager (ICH & VM), an assistant care home manager (ACHM) who was previously in the CSM role and the clinical services manager (CSM). The ICH & VM has been in the role for eight weeks. At the time of the audit, the role was extended out for another three months. Responsibilities and accountabilities are defined in job descriptions and individual employment agreements reviewed. All of the management team confirmed their knowledge of the aged care sector and maintain currency through regular ongoing clinical and management education related to their individual roles. This was confirmed in education documentation sighted.

		The service holds contracts with the DHB for rest home, hospital, respite, long term support chronic health conditions (LTSCHC) and primary options for acute care (POAC) and residents on accident compensation corporation (ACC) contracts. There were 108 residents on the day of audit; 40 rest home and 68 hospital level care residents including one LTSCHC under 65 years, one ACC and one person receiving respite care (all hospital level care).
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	When the ICH & VM is absent, the ACHM can carry out all the required duties under delegated authority. During absences of key clinical staff, the CSM who is experienced in the sector can take responsibility for any clinical issues that may arise. Staff reported the current arrangements work effectively. Two unit coordinators (UCs) are also available if needed to cover clinical issues.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA 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 accidents, complaints, audit activities, a regular resident satisfaction survey (2021 - which had been completed but not analysed at the time of this audit), monitoring of outcomes, clinical incidents including any infections, falls, skin tears, wounds, challenging behaviour and pressure injuries.</p> <p>Meeting minutes confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly management quality and staff meetings.</p> <p>Staff reported their involvement in quality and risk management activities through audit activities. Relevant corrective actions are developed and implemented to address any shortfalls. Resident and family members interviewed expressed positive views on the staff and services provided. The ICH & VM stated that any concerns raised by residents or family/whanau are followed up using the corrective action process.</p> <p>Policies reviewed cover all necessary aspects of the service delivery and contractual requirements; however, they have not been reviewed in a timely manner. The document control system to manage the policies and procedures from support office is being addressed. However, if policies are outdated this is not appropriate for staff orientating to new roles of employment. Any obsolete documents are removed from the system and stored appropriately and can be retrieved if needed.</p> <p>The ICM & VM described the processes for the identification, monitoring and reporting of any risks and</p>

		<p>development of mitigation strategies. The management team are fully informed and familiar with the Health and Safety at Work Act (2015) and the requirements have been implemented. The service has a health and safety team who actively maintain and review all known and newly identified hazards and risks. The maintenance manager interviewed is very involved in health and safety and civil defence processes for the service and ensures the hazard registers are maintained and are current for each area of service delivery.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff documented adverse and near miss events on the electronic system in place and this generates an incident form. Each resident has their own incident register. The CSM is alerted if this occurs on any shifts. Incidents sampled were investigated, action plans developed, and actions followed up in a timely manner. Adverse event data is collated, analysed and reported in the monthly reports by the clinical manager and reports are sent to the ICH & VM and to the CSM for review. A monthly report is collated of the whole site.</p> <p>The ICH & VM and the CSM described essential notification reporting. They advised that there have been nine section 31 notices completed and sent to HealthCERT since the previous audit. There have been no police investigations, coroner's requests, issues-based audits and any other notifications, such as infection outbreaks, during this time.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource management policies, procedures and processes are based on good employment practice and required legislation. The recruitment process includes police vetting checks, referee checks and validation of qualifications and annual practising certificates (APCs) for all health professionals employed and/or contracted to the service. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained. The service is actively recruiting registered nurses, and this is ongoing.</p> <p>Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. A quality improvement initiative was generated in regard to the orientation provided and a checklist was developed and implemented. In addition to this the length of time for orientation was increased. Any bureau staff who work at this facility receive specific orientation provided by the registered nurses. A checklist is completed to verify this orientation has occurred. Outcomes have included less complaints from other staff and work logs are being completed more efficiently. Any issues are discussed at the six week review for all new staff. Staff appraisals are undertaken annually, and records are maintained electronically and were in the individual staff records reviewed.</p> <p>The Heritage education plan for 2021 was reviewed. Continuing education is planned on an annual</p>

		<p>basis, including all mandatory training requirements. Care staff have either completed or commenced a New Zealand Qualification Authority (NZQA) education programme to meet the requirements of the provider's agreement with the DHB. There are 53 healthcare assistants and 17 have completed a relevant level four qualification on the NZQA framework, 16 level three, eight level two and 12 are either enrolled and/or have not yet enrolled into the training. Two of the three activities staff have completed level 4 diversional therapy training. Sixteen of 18 registered nurses are interRAI competent to complete the required interRAI assessments on admission and six monthly thereafter. Registered nurses can attend elective study days and training as well as being involved in the Heritage training 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 delivery 24 hours a day seven days a week (24/7). Observations of six weeks of staff rosters identifies that the facility adjusts staffing levels to meet the changing needs of residents. Staff are replaced in any unplanned absence. An afterhours on call roster is in place with staff interviewed reporting that good advice is available when needed. The clinical services manager, unit co-ordinators and assistant care home manager have a week about system in place. The service does use bureau staff as needed. Care staff reported there were adequate staff available and team work is more evident. Family and residents interviewed supported this. All registered nurses have complete first aid training and a list of staff is maintained with these additional skills.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>All necessary demographic, personal, clinical and health information was fully completed in the residents' files sampled for review. Clinical notes were current and integrated with GP and allied health service provider notes. This includes interRAI assessment information entered into the Momentum electronic database. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable using a cataloguing system.</p> <p>Residents' files are held for the required period before being destroyed. No personal or private resident information was on public display during the audit.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written information about the service and the admission process. The organisation seeks updated information from the</p>

<p>manner, when their need for services has been identified.</p>		<p>NASC and GP for residents accessing respite care.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the 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/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. Family members of residents who had been transferred, reported being kept well informed during the transfer of their relative.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policy was current and identified all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care.</p> <p>A safe system for medicine management using an electronic system was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medication competency is reviewed annually.</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.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries.</p> <p>The records of temperatures for the medicine fridge and the medication room reviewed were within the recommended range.</p> <p>Good prescribing practices noted included 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. Standing orders are not being used.</p> <p>There were 12 residents self-administering medications at the time of audit. Appropriate processes</p>

		<p>were in place to ensure this is managed in a safe manner.</p> <p>There is an implemented process for comprehensive analysis of any medication errors. The Ministry of Health was notified in December 2020 about a medication error and corrective actions raised were actioned.</p> <p>A medication audit was completed in March 2021 as per the audit schedule. No vaccines were stored onsite.</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>	FA	<p>The food service is provided on site by a team of four cooks and five kitchen hands and was in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian in May 2021. Recommendations made at that time have been implemented.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The service operates with an approved food safety plan and registration issued by Auckland City Council which expires on 30/12/2021. Food temperatures, including for high-risk items, are monitored appropriately and recorded as part of the plan. The cooks have undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training.</p> <p>A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, is available.</p> <p>Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. A meal satisfaction survey was completed in March 2021. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p>	FA	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is currently no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative.</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, a referral for reassessment to the NASC is made and a new placement found, in consultation with the resident and whānau/family. Examples of this occurring were discussed. There is a clause in the access agreement</p>

organisation, where appropriate.		related to when a resident's placement can be terminated.
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents are assessed to develop an initial care plan. Within three weeks of admission, a comprehensive assessment is completed using nursing assessment tools, such as a pain scale, acuity level, falls risk, mobility, skin integrity, dietary profile, nutritional and interRAI, as a means to identify any deficits and to inform long term care planning. The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by trained interRAI assessors on site. Residents and families confirmed their involvement in the assessment process.</p> <p>Files audited has evidence of wound management, such as wound care plans and evaluation. Evidence of wound management, including photographs of chronic wounds, was sighted. 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>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. Residents and families reported participation in the development and ongoing evaluation of care plans.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified that 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 of high standard. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the</p>	FA	<p>The activities programme is provided by a trained diversional therapist holding the national Certificate in Diversional Therapy, and two activities coordinators.</p>

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>An initial social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The residents' activity needs are evaluated as part of the formal six monthly care plan reviews.</p> <p>Activities reflected residents' goals, ordinary patterns of life and included normal community activities. Individual, group activities and regular events are offered. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they were satisfied with the programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Residents care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN.</p> <p>Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short-term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for residents with infections, wounds, and those with a falls risk. When necessary, and for unresolved problems, long term care plans are added to and updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Residents are supported to access or seek referral to other health and/or disability service providers. Although the service has a contracted GP, residents may choose to use another medical practitioner. 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, including to a wound nurse, dietitian, the hand clinic, gastroscopy, and general surgery. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p>	<p>FA</p>	<p>Staff follow documented processes for the management of waste and infectious substances. Appropriate signage is clearly displayed where necessary. The maintenance manager and staff who handle chemicals have completed relevant education related to safe chemical handling. Certificates</p>

<p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>		<p>were sighted in the personal records reviewed. Material data sheets were available where chemicals are stored and staff interviewed knew what to do should there be a chemical spill/event occur.</p> <p>There is provision and availability of protective clothing and equipment and staff were observed using this during the audit.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There are two separate buildings and each had their own building warrant of fitness (BWOFF) displayed. The rest home BWOFF expires 31 May 2022 and the hospital 28 September 2021. Equipment electrical checks were completed on the 26 – 28 May 2021, a full environmental check was completed 14 June 2021 and the bio-medical equipment checks and calibration was completed 3 June 2021 and the verification report was sighted. Testing of hot water temperatures are performed across all services three monthly and random rooms are selected monthly. The maintenance manager is fully informed of reporting any variances to management and this would be actioned immediately.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. All residents' rooms have a hand basin. All wings have a large bathroom with a shower and toilet for every four to five residents. There are also separate shower and separate toilets available. Appropriately secured and approved handrails are provided in the toilet and shower areas and other equipment and accessories are available to promote residents' independence.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>Adequate personal space is provided to allow residents and staff to move around within their bedrooms safely. At the time of the audit, all bedrooms are single occupancy. There are no shared rooms. Each room has a double wardrobe. Rooms are personalised with furnishings, photographs and other personal items displayed.</p> <p>A new initiative was for the maintenance manager to build a new shed for the total mobility scooters when not in use and/or recharging batteries. This area is well used. In addition to this, an area off the hospital laundry was closed in, so that when residents' chairs are cleaned they can stay dry and under cover for as long as needed prior to placing back into the lounges or the resident's individual rooms.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>Communal areas are available for residents to engage in activities. There are three lounges in the hospital care setting and one in the rest home. In addition to this, there are small lounges in both facilities. The hospital is on two levels with a lounge and dining area on each floor. The rest home is on one level only and has one large lounge and two smaller lounges that residents can access for privacy if required. Lounge and dining facilities have appropriate seating for frail and older persons. There are large areas for external activities and/or to walk in the gardens provided. Table and chairs and shade are provided as needed with use of umbrellas in the summer months available.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are two designated laundry spaces, one in the rest home and one in the hospital. Three staff are employed to cover the laundry service which operates seven days a week. The laundry person interviewed works in both sites. The environment was clean and organised with clean/dirty designated areas. Chemicals are locked in each service area with signage being available. Training is provided to all staff by product representatives from the contracted services and an eco-system is in place for the washing machines. All linen and clothes are put away daily. All residents at the time of audit reported the laundry is well managed and their clothes are returned in a timely manner. The cleaners are rostered, one in each area (two rostered on if needed) daily, and they had a good understanding of their role and infection prevention and control processes. Store areas are provided for the cleaning trollies in the locked sluice rooms when not in use. Personal protective equipment is readily available and staff were observed wearing this during the audit.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>Policies and guidelines for emergency planning, preparation and responses are displayed and known to staff. Disaster and civil defence planning guides provide directions for disasters and described the procedures to be followed in the event of a fire or other emergency. The Ministry of Civil Defence and Emergency Management recommendations for the region are met in relation to appropriate stocks of water and food. Approximately 4000 litres of water is stored in two tanks near the hospital, plus ten, ten litre containers of drinking water that is replaced annually. Emergency lighting is tested regularly. The service has an arrangement to hire a generator if needed as a resource for any power outage. There are adequate supplies of blankets, mobile phones, food and first aid supplies to meet the requirements of 108 residents.</p> <p>The current fire evacuation plan was approved by the New Zealand Fire Service on the 26 May 2007 and no changes have been made to the building footprint since then.</p> <p>A trial evacuation takes place six monthly with a copy sent to the New Zealand Fire Service, the most recent being held 11 January 2021. The orientation programme includes fire and security training. Staff</p>

		<p>confirmed their awareness of the emergency procedures.</p> <p>Call bells alert staff to residents requiring assistance. The maintenance manager completes call bell audits and sends a report to the ICH & VM. A new system has been installed since the previous audit. Residents and staff reported that staff respond promptly to call bells.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Under floor heating is supplied from diesel fired boilers, which are checked daily, in each facility. Quotes are being undertaken presently to change from diesel to electric supplies as a positive initiative for the environment. The lounge/dining areas in the rest home has a ceiling heat pump in place. Only one resident's room in the rest home has a wooden floor and this room has an electric heater in place. A heat pump is situated in the education/board room. Rooms have natural light and opening external 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 the size and scope of the service.</p>	FA	<p>The service implements an infection prevention and control (IPC) programme to minimise the risk of infection to residents, staff and visitors. The programme is guided by a comprehensive and current infection control manual. The infection control programme and manual are reviewed annually.</p> <p>The registered nurse 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 clinical services manager and tabled at the IPC committee meeting. This committee includes the care home manager, IPC coordinator, and representatives from food services and household management.</p> <p>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. Due to the Covid-19 pandemic all visitors are requested to log their visit by entering their details on a paper log or by scanning a Ministry of Health bar code. The infection control manual provides guidance for staff about how long they must stay away from work if they have been unwell. Staff interviewed understood these responsibilities.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and</p>	FA	<p>The IPC coordinator has appropriate skills, knowledge and qualifications for the role. She has attended relevant study days on infection prevention and control, as verified in training records sighted. Additional support and information is accessed from the infection control team at the 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 IPC coordinator confirmed the availability of resources to support the programme and any outbreak</p>

meet the needs of the organisation.		of an infection. A scabies outbreak was reported in January 2020. It was reported to the Ministry of Health in a timely manner. The summary of the report identified areas for improvement and three corrective actions were raised. Documents reviewed and staff interviews verified that the corrective actions were actioned.
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Most infection control policies were last reviewed in 2020 and included appropriate referencing. The management of scabies procedure is in draft format and the outbreak management procedure has not been reviewed in last two years (refer Criterion 1.2.3.4).</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 suitably qualified RNs and the IPC coordinator. Content of the training is documented and evaluated to ensure it is relevant, current and understood. A record of attendance is maintained. When an infection outbreak or an increase in infection incidence has occurred, there was evidence that additional staff education had been provided in response. Hand washing and donning and doffing of personal protective equipment trainings have been completed as a part of the recent pandemic preparedness.</p> <p>Education with residents is generally on a one-to-one basis and has included reminders about handwashing, advice about remaining in their room if they are unwell and increasing fluids during hot weather.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods</p>	FA	<p>Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, skin, eye, wound, the upper and lower respiratory tract and scabies. The IPC coordinator 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>that have been specified in the infection control programme.</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. Trends for the current year and comparisons against previous years are reported to the IPC committee. Data is benchmarked externally within the group. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.</p> <p>A summary report for a recent scabies infection outbreak was reviewed and demonstrated a thorough process for investigation and follow up. Learnings from the event have now been incorporated into practice, with additional staff education implemented.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator is a unit coordinator and has been in this role for six months. The coordinator provides support and oversight for enabler and restraint management in the facility and demonstrated a sound understanding of the organisation's policies, procedures and practice and the role and responsibilities.</p> <p>On the day of audit, three restraints were in use and five enablers. Enablers were the least restrictive and used voluntarily at the residents' request. All residents using enablers had signed consents stating they were voluntary. Enabler use was identified on residents' care plans reviewed.</p> <p>The restraint coordinator stated that restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint approval group minutes, residents' records reviewed and from interview with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	<p>FA</p>	<p>The restraint approval group consist of the general practitioner (GP), family member, restraint coordinator and an RN and they are responsible for the approval of the use of restraints and the restraint process. It was evident from review of restraint approval group meetings, residents' records and interviews with the coordinator that there are clear lines of accountability and that all restraints have been approved and the overall use of restraints is being monitored and analysed. The unit coordinator commented that the numbers of both restraints and enablers has decreased since the previous audit. Use of a restraint or an enabler is part of the interRAI assessment and the plan of care.</p>

<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Assessments for the use of restraint were documented and included all requirements of the Standard. The RN undertakes the initial assessment with the restraint coordinator's involvement and input from the resident's family. The restraint coordinator described the documented process. Families confirmed their involvement. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks. The desired outcome was to ensure the resident's safety and security. Completed assessments were sighted in the records of residents who were using a restraint.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraints is actively minimised. The restraint coordinator described how the alternatives to restraints are discussed with staff and family members. When restraints are in use, frequent monitoring occurs to ensure the resident remains safe. Records of monitoring had the necessary details. Access to advocacy is provided if requested and all processes ensure dignity and privacy are maintained and respected at all times.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of residents' records demonstrated that the use of restraints are reviewed and evaluated during interRAI reviews and care plans are updated six monthly. Restraint evaluations are discussed at the restraint approval group meetings also held six monthly. Families interviewed confirmed their involvement in the evaluation process and their satisfaction with the restraint process. The evaluation covers all requirements of the Standard, including future options to eliminate the use of restraint, the impact and any outcomes achieved, if the policy and procedure was followed and that documentation was completed as required.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint committee undertakes six monthly review of all restraint use which includes all the requirements of the Standard. Six monthly restraint meetings and reports are completed and individual use of restraint use is reported to the quality and staff meetings. Minutes of meetings were reviewed and confirmed that this includes analysis and evaluation of the amount and type of restraint use in the facility, whether all alternatives to restraint have been considered, the effectiveness of the restraint in use, the competency of staff and the appropriateness of restraint/enabler education and feedback from the doctor, staff and families.</p> <p>A six monthly internal audit that is carried out also informs these meetings. Any changes to policies, procedures, guidelines and processes are implemented if indicated. Data reviewed, minutes of meetings held and interviews with the restraint coordinator confirmed that the use of restraint has</p>

		reduced since the last audit.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.4</p> <p>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.</p>	PA Low	<p>The document control system is managed from the organisation’s compliance and risk team at support office. The documentation audit performed prior to the audit and the documents reviewed onsite at audit reflected policies and procedures as being out of date. Policies and procedures guide staff and staff interviewed commented on this issue as part of the orientation process.</p> <p>Obsolete documents are stored for the required timeframe (1.2.3.3) and then are be destroyed appropriately as per the policy reviewed.</p>	<p>The policies and procedures reviewed had not all been reviewed in the timeframes required in line with the document control system in place. Newly employed staff are not able to access current documents when needed to guide them in practice.</p>	<p>Ensure the document control system is managed effectively to ensure policies and procedures are reviewed, approved, up to date and available to staff.</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.