

Patrick Ferry House Limited - Patrick Ferry House

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity: Patrick Ferry House Limited

Premises audited: Patrick Ferry House

Services audited: Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

Dates of audit: Start date: 29 June 2021 End date: 30 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: 72

Executive summary of the audit

Introduction

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

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

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

Key to the indicators

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

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

General overview of the audit

Patrick Ferry House provides rest home and hospital (geriatric and medical) level care for up to 74 residents. On the day of the audit there were 72 residents. The service is managed by an experienced manager with the general manager and head office staff providing support and oversight. There is a hospital manager and clinical manager on site. The residents and relatives interviewed all spoke positively about the care and support provided.

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

Patrick Ferry House has a documented quality and risk management programme. The owner has invested in technological advancement since the last audit including implementation of a new clinical management system. Furniture has been replaced in lounges and bedrooms and wall hangings have been renewed.

This audit identified an improvement required around the quality improvement programme in relation to documented in meeting minutes.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Policies are documented to support resident rights and residents state that their rights are upheld. Individual care plans include reference to residents' values and beliefs. Residents and relatives are kept up to date when changes occur or when an incident occurs. Systems are in place to ensure residents are provided with appropriate information to assist them to make informed choices and give informed consent.

A complaints policy is documented that aligns with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). A complaints register is maintained. Consents are documented by residents or family and there are advance directives documented if the resident is competent to complete these.

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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The service has support from head office that includes the general manager, with operational management provided by the hospital manager. The clinical manager started in the role in January 2021. Both have management experience for over 10 years, and both are registered nurses.

There is a documented quality and risk management programme with key components of the system including management of complaints, implementation of an internal audit schedule, annual satisfaction surveys, incidents and accidents, review of infections, and review of risk and monitoring of health and safety, including hazards.

Human resource policies are in place, including a documented rationale for determining staffing levels and skill mixes. A roster provides sufficient and appropriate staff coverage for the effective delivery of care. An orientation and training programme is documented. Registered nursing cover is provided 24 hours a day, 7 days a week.

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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The registered nurses are responsible for each stage of service provision. A registered nurse assesses and reviews residents' needs, outcomes, and goals with the resident and/or family/whānau input. Care plans viewed demonstrate service integration and are reviewed at least six- monthly. Resident files include medical notes by the contracted general practitioner (GP), and visiting allied health professionals.

Medication policies reflect legislative requirements and guidelines. Registered nurses and medication competent health care assistants responsible for the administration of medicines complete education and medication competencies. The electronic medication charts are reviewed three-monthly by the GP.

The diversional therapist and activities coordinator implement the activity programme to meet the individual needs, preferences, and abilities of the residents. Residents are encouraged to maintain community links. There are regular entertainers, outings, and celebrations. Residents and families reported satisfaction with the activities programme.

All meals are cooked on site. Residents' food preferences, dislikes and dietary requirements are identified at admission and accommodated. There are nutritious snacks available at all times.

Safe and appropriate environment

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

Standards applicable to this service fully attained.

The building holds a current warrant of fitness. Fixtures, fittings, and flooring are appropriate and toilet/shower facilities are constructed for ease of cleaning. Staff are provided with access to training and education to ensure safe and appropriate handling of waste and hazardous substances.

Electrical equipment has been tested and tagged. All medical equipment and all hoists have been serviced and calibrated. Residents can freely mobilise within the communal areas with safe access to the outdoors, seating, and shade. Cleaning and laundry services are monitored through the internal auditing system. Appropriate training, information, and equipment for responding to emergencies are provided. There is an emergency management plan in place and adequate civil defence supplies in the event of an emergency. There is an approved evacuation scheme and emergency supplies for at least three days.

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.

There is a restraint policy that includes comprehensive restraint procedures. There is a documented definition of restraint and enablers that aligns with the definition in the standards. There is a restraint register and a register for enablers. Three residents require the use of restraint for their safety with two residents choosing to use an enabler.

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 control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control coordinator (clinical manager) is responsible for coordinating/providing education and training for staff. The infection control manual outlines a comprehensive range of policies, standards and guidelines, training and education of staff and scope of the programme. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. The service engages in benchmarking with its sister facility. There has been one outbreak in the previous year, which was appropriately managed.

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	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with managers (the general manager, hospital manager, clinical manager) and staff (four healthcare assistants, two registered nurses (RN), one clinical coordinator, one diversional therapist, one laundry, one cleaner, one activities coordinator, one maintenance, kitchen manager), confirm their familiarity with the Code.</p> <p>Interviews with 12 residents (two rest home and 10 hospital), and six families (six hospital) confirm the services being provided are in line with the Code. The Code is discussed at some resident, staff, and quality meetings (link 1.2.3.6).</p> <p>Code of rights training including advocacy, informed consent, privacy, and elderly abuse are part of the mandatory training days that staff undertake which are facilitated twice a year to ensure all staff attend.</p>
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they	FA	<p>There is an informed consent policy. In all nine files reviewed, (six hospital including one under interim care funding, one ACC funded and one long term service – chronic health condition [LTS-CHC], and three rest home residents), residents had general consent forms signed on file. Care staff were knowledgeable around informed consent. Residents and relatives interviewed could</p>

need to make informed choices and give informed consent.		<p>describe what informed consent was and knew they had the right to choose. There is an advance directive policy.</p> <p>There was evidence in files reviewed of family/EPOA discussion with the GP for a medically indicated not for resuscitation status. In the files reviewed, there were appropriately signed resuscitation plans and advance directives in place. Discussions with relatives demonstrated they are involved in the decision-making process, and in the planning of resident's care. Admission agreements had been signed and sighted for all the files reviewed. Copies of EPOAs were on resident files where available.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>A policy describes access to advocacy services. Staff receive training on advocacy. Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</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 encouraged to be involved in community activities and maintain family and friends' networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</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 service has a complaints policy that describes the management of complaints. There are complaint forms available. Information about complaints is provided on admission. Interview with residents and families demonstrated an understanding of the complaints process. All staff interviewed could describe the process around reporting complaints.</p> <p>There is a complaint register. Verbal and written complaints are documented. There have been eight complaints in 2020 and one complaint year to date. The complaint documentation was reviewed. Four complaints reviewed noted investigation, timeframes, corrective actions when required, and resolutions in place if required.</p> <p>Two complaints involved the Health and Disability Advocate, and one complaint was lodged with the district health board. All complaints involving external parties have been closed out with no</p>

		<p>identified issues in respect of the complaints.</p> <p>The Ministry requested follow up against aspects of a closed HDC complaint that included communication, complaints management, family/ whanau participation, Service provider availability, Entry to services, and Service delivery/interventions. There were no identified issues in respect of this complaint.</p> <p>Discussions with residents and families confirmed that their issues are addressed, and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the Code on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the hospital manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code.</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>The service has policies which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>There is a policy that describes spiritual care. A pastor and a representative from the Catholic Church visit regularly. All residents interviewed indicated that residents' spiritual needs are being met when required.</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>The service has established cultural policies to help meet the cultural needs of its residents. The service has links with Awataha Marae. There is a Māori health plan. There were no residents who identified as Māori on the day of the audit.</p> <p>Discussions with staff confirm that they are aware of the need to respond to cultural differences and described how they would document the care plans for the specific cultural requirements of Māori residents.</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>The service has established cultural policies aimed at helping meet the cultural needs of its residents. The service has recently introduced a new initiative called "Food for the Soul", which is incorporated into the activity programme. This initiative aims to meet the spiritual needs of the wide range of multicultural residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met.</p> <p>Information gathered during assessment including residents' cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff receive training on cultural awareness.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The registered nurses supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy, and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that align with the health and disability services standards, for residents with aged care needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident and family satisfaction survey were sent out in 2021 to and the 37 completed survey forms returned demonstrated high levels of satisfaction with the services provided. The resident meeting has a standard agenda that asks the residents for ideas each month about how to improve the service. There was evidence that the residents' feedback (as appropriate) is acted upon. Residents interviewed spoke very positively about the care and support provided and stated the management team are very approachable. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>Residents interviewed stated they were welcomed on entry and were given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any</p>

provide an environment conducive to effective communication.		accident/incident and ensure full and frank open disclosure occurs. Nineteen incidents/accidents forms were reviewed. The forms included a section to record family notification. All forms indicated whether the family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Patrick Ferry House is an aged care facility located on the North Shore. There are 74 dual-purpose rest home and hospital (geriatric and medical) level beds. On the day of the audit there were 72 residents. The service is provided over two levels. On the day of audit, there were 38 residents (eight rest home and 30 hospital) across the 39 rooms on the ground floor. On level one, there were 34 residents (nine rest home and 25 hospital) across the 35 beds. There were six residents under an interim care contract (medical, all requiring hospital level of care), two under ACC funding, one private paying resident, one hospital level LTS-CHC funded resident and all others were under the Age-Related Care Contract.</p> <p>A business plan is in place for 2021. A mission, philosophy and objectives are documented for the service. The hospital manager completes a weekly report for the general manager and then meets at least fortnightly to review the day-to-day operations and to review progress towards meeting the business objectives.</p> <p>The hospital manager has previous health management experience and has been in the role at this facility for three years. Prior to the role as hospital manager, they had 16 years' experience in aged care. The hospital manager is supported by a clinical manager. The clinical manager has worked in the role at Patrick Ferry House since January 2021, has three years' experience in aged care and has a further 10 years' experience in management overseas. The hospital and clinical managers have maintained a minimum of eight hours of professional development relating to managing an aged care service.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	In the absence of the hospital manager, the clinical manager is in charge with support from the general manager and the other care staff.

<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>	<p>PA Low</p>	<p>A quality and risk management programme is in place. Interviews with the general manager, hospital manager, clinical manager, clinical coordinators, registered nurses, care staff and other staff, reflected their understanding of the quality and risk management systems that have been put into place.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. Policies are regularly reviewed. Policies and procedures have been updated to include reference to the Privacy Act that was reviewed in 2020. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. Staff are requested to sign that they have read the new/revised policies.</p> <p>Quality management systems are linked to internal audits, incident and accident reporting, health and safety reporting, infection control data and complaints management. Data is being collected monthly through eCase and analysed or trended and the results are communicated to staff. Corrective actions are documented and communicated to staff through relevant meetings. Meetings held include monthly staff meetings, two weekly registered nurse meetings that include the hospital and clinical manager along with the clinical coordinator and the RNs, as required meetings with household staff and activities staff, and one to two monthly resident meetings. Staff and registered nurse meetings do not always reflect discussion around aspects of the quality programme.</p> <p>A number of quality improvements have been made since the last audit, including purchasing of new equipment including hoists, mattresses, kitchen equipment, and thermoscans; updated computer systems, set up skype for resident / family communication, and implemented eCase computerised patient management system; and changed the chemical supplier due to supply and quality concerns.</p> <p>A health and safety programme is in place that meets current legislative requirements. An interview with the health and safety officer (administrator) and review of health and safety documentation confirmed that legislative requirements are being met. External contractors have been orientated to the facility's health and safety programme. The hazard register is regularly reviewed. Falls prevention strategies are implemented for individual residents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by</p>	<p>FA</p>	<p>There is an accidents and incidents reporting policy. The hospital manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly staff meetings. A registered nurse conducts clinical follow-up of residents. Ten incident forms sampled from June 2017 demonstrated that appropriate clinical</p>

the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.		follow-up and investigation occurred following incidents. Discussions with the hospital manager and clinical manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications.
<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>There are human resource management policies in place. This requires that relevant checks are completed to validate the individual's qualifications, experience, and veracity for new staff. A copy of practising certificates is kept. Nine staff files were reviewed (hospital manager, clinical manager, three registered nurses, two healthcare assistants, one diversional therapist, one kitchen manager) and evidence that reference checks were completed before employment is offered. A signed contract was on each file along with police checks and a job description.</p> <p>The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. The in-service education programme for 2021 has been reviewed and a plan is being implemented. To date, all care staff have completed competencies including mediation, oxygen, Medimap, pressure injuries, calculations, restraint, hand hygiene, fire safety, infection control, warfarin, and insulin. Other training programmes are being implemented with good attendance to those that have been offered. Annual staff appraisals were evident in all staff files reviewed.</p> <p>the RNs have had training in 2021 around key topics that relate to residents under a medical care contract including pain management (advanced) including training from the pharmacist, wound assessment, management and pressure injury prevention, male catheterisation, continence and interventions, the aging urinary tract, understanding frailty and cardiac disease. Staff have also had training in the past year around palliative care and end of life support. Staff have been involved in putting together an end-of-life booklet for families with training around this.</p> <p>The hospital manager and registered nurses can attend external training, including sessions provided by the local DHB. Seven registered nurses as well as the clinical coordinator and clinical manager have completed interRAI training. There are 16 healthcare assistants who have completed CareerForce level 4; four completed level 3; two with level 2. Staff interviewed were knowledgeable and skilled.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from</p>	FA	<p>Policy includes staff rationale and skill mix. Sufficient staff are rostered to manage the care requirements of the residents. The hospital manager is onsite Monday to Friday and is on call after hours.</p> <p>The hospital manager and the clinical manager work Monday to Friday and share the afterhours on</p>

<p>suitably qualified/skilled and/or experienced service providers.</p>		<p>call. On a morning shift on each floor there is a clinical coordinator (registered nurse) rostered on Monday to Friday.</p> <p>Numbers of staff allocated to the ground floor and to level one are the same. On the ground floor there are 38 residents (eight rest home and 30 hospital) on the ground floor. On level one, there are 34 residents (nine rest home and 25 hospital).</p> <p>Each floor has the following: five healthcare assistants (four full shift and one short shift) in the morning; four healthcare assistants (three long and one short shift) in the afternoon; two healthcare assistants on each floor overnight. There is a registered nurse on each floor on the morning and afternoon shifts and one registered nurse overnight who works across both floors. One of the healthcare assistants on the morning and afternoon shifts is designated as the shift coordinator. The shift coordinator or a senior HCA would attend to a call out to the village attached if required. The registered nurse on nights does not attend to residents in the attached village. The hospital manager advised that there are approximately one to two call outs a week and most are for minor problems e.g. they have locked themselves out. The care staff interviewed advised that additional staff are provided when there is an increase in resident care needs.</p> <p>Activities staff are rostered on five days per week. There are separate domestic staff who are responsible for cleaning and laundry services.</p> <p>Interviews with staff, residents and family members identified that staffing is adequate to meet the needs of residents.</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>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Residents' files are protected from unauthorised access by being locked away in the nurses' stations and electronic files are password protected. Sensitive resident information is not displayed in a way that can be viewed by other residents or members of the public. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse. Files are integrated.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been</p>	<p>FA</p>	<p>There is an implemented organisational admission policy. All residents have a needs assessment completed prior to entry that identifies the level of care required. The hospital manager and clinical manager screen all potential enquiries to ensure the service can meet the required level of care and specific needs of the resident.</p> <p>An information pack including all relevant aspects of the service, advocacy and health and disability</p>

identified.		information is given to residents/families/whānau at entry. All relatives interviewed were familiar with the contents of the pack. The admission agreement provides information on services which are excluded, and examples of how services can be accessed that are not included in the agreement.
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>The service has a policy that describes guidelines for death, discharge, transfer, documentation and follow up. A record of transfer documentation is kept on the resident's file. All relevant information is documented and communicated to the receiving health provider or service. The DHB 'yellow envelope' initiative is used to ensure the appropriate information is received on transfer to hospital and on discharge from hospital back to the facility. Communication with family is made. Care staff interviewed could accurately describe the procedure and documentation required for a resident transfer out of, and admission in to the facility.</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>	FA	<p>There are comprehensive policies and procedures in place for all aspects of medication management, including self-administration. There were no residents self-medicating on the day of audit. There are no standing orders in use and no vaccines stored on-site.</p> <p>The facility uses an electronic medication management and robotic pack system. Medications are checked on arrival and any pharmacy errors recorded and fed back to the supplying pharmacy. Registered nurses and medication competent healthcare assistants administer medications, have up to date medication competencies and there has been medication education in the last year. Registered nurses have syringe driver training completed by the hospice. The medication fridge and room temperatures are checked daily and are within the required ranges. Eye drops viewed in both medication trolleys had been dated once opened.</p> <p>Staff sign for the administration of medications electronically. Eighteen medication charts were reviewed. Medications are reviewed at least three-monthly by the GP. There was photo identification and allergy status recorded. 'As required' medications had indications for use charted.</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>All meals at Patrick Ferry House are prepared and cooked on-site. There is a qualified chef and a cook that covers the seven-day week. There is a four-weekly seasonal menu which has been reviewed by a dietitian. Meals are plated in the kitchen and then served in the ground floor dining room. Food is delivered in a bain marie to the upstairs kitchenette. Both dining rooms have a first and second meal service ensuring those requiring additional assistance have their dignity maintained and meals served at an acceptable temperature. End cooked meal, and fridge and</p>

		<p>freezer temperatures are recorded.</p> <p>Dietary needs are known with individual likes and dislikes accommodated. Cultural and religious food preferences are met. There is a system to identify residents who require monitoring of food intake. Specialised crockery and utensils are available to help promote independence at mealtimes.</p> <p>Residents were observed enjoying their lunch in one dining room and a healthcare assistant was observed assisting a resident to eat in their room. Residents' meetings allow for the opportunity for resident feedback on the meals and food services. Residents interviewed were complimentary of the food and confirmed alternative food choices were offered for dislikes.</p> <p>All staff who work in the kitchen have completed food safety and hygiene, and chemical safety training.</p> <p>All foods were date labelled and stored correctly.</p> <p>A current food control plan is in place.</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 organisation, where appropriate.</p>	FA	<p>The reason for declining service entry to potential residents should this occur, is communicated to the potential resident or family/whānau and they are directed to the original referral agent for further information. The reasons for declining entry would be if the service had no beds available or could not provide the level of care.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>Files sampled indicated that all appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. InterRAI assessments had been completed for all long-term residents' files reviewed including an LTS-CHC and ACC funded resident. Six monthly InterRAI assessments and reviews are evident for six of nine resident files sampled as one hospital and one rest home resident had been in the service less than six months, one hospital level resident was on a short-term interim care contract.</p> <p>Resident files reviewed identify that risk assessments are completed on admission and reviewed six-monthly as part of the evaluation unless changes occur prior, in which case a review is carried out at that time. Additional assessments for management of behaviour, pain, wound care, nutrition, falls and other safety assessments including restraint, are appropriately completed according to need. For the resident files reviewed, the outcomes from assessments and risk assessments are reflected into care plans.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Care plans reviewed demonstrated service integration and input from allied health. Resident care plans were resident centred and support needs and interventions were documented to reflect the resident goals. All care plans had been updated to reflect the resident's current health status as needs changed. Family members interviewed confirm care delivery and support by staff is consistent with their expectations. Residents (if appropriate) and family stated they were involved in the care planning and review process. Falls prevention and management strategies were included in the long-term care plan in two of the two residents with classified as being a high falls risk.</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>When a resident's condition changes, the RN will initiate a GP consultation. Staff stated that they notify family members about any changes in their relative's health status. Care plans have been updated as residents' needs changed. The general practitioner interviewed was complimentary of the service and care provided.</p> <p>Care staff stated there are adequate clinical supplies and equipment provided, including continence and wound care supplies and these were sighted.</p> <p>Wound assessment, wound management and evaluation forms are in place for all wounds. Wound monitoring occurred as planned and there are also photos to show wound progress. Wounds included six chronic wounds, ten skin tears, one grade 1 pressure injury (non-facility acquired), three grade 2 pressure injuries (two non-facility acquired), and three unstageable pressure injuries (two non-facility acquired). The facility acquired unstageable pressure injury belongs to a resident refusing interventions including repositioning. Wound nurse specialist and DHB virtual wound clinic involvement are evident in chronic wound and pressure injury management.</p> <p>Monitoring forms are in use as applicable, such as weight, vital signs, and wounds. All monitoring requirements including pain and neurological observations and had been documented as per policy. Two residents interviewed stated their pain was well managed.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	FA	<p>There is one diversional therapist and one activities coordinator covering Monday to Friday who plans and leads all activities. The service designates weekends as 'family time' and also arranges activities on some 'themed' weekends such as Easter or Mother's Day. Resources are set up in advance and left out for resident/family use during weekends and out of hours. Residents were observed participating in planned activities during the time of audit.</p> <p>There is a weekly programme in large print on noticeboards in all areas. Residents have the choice</p>

		<p>of a variety of activities which are varied according to resident preference and need. These include (but are not limited to) exercises, happy hour, crafts, games, quizzes, entertainers, pet therapy, floor games and bingo.</p> <p>Those residents who prefer to stay in their room or cannot participate in group activities have one-on-one visits and activities such as hand massage are offered.</p> <p>There are regular outings, and the service utilises the adjoining village's accessible minibus. The facility also has a wheelchair friendly boardwalk through garden areas leading to a gazebo. Residents are assisted on the boardwalk as weather permits. There are regular entertainers visiting the facility. Special events like birthdays, St Patrick's, Mothers' Day, and Anzac Day are celebrated. There are visiting community groups such as churches and children's groups.</p> <p>Residents have an activity assessment completed over the first few weeks following admission, that describes the residents past hobbies and present interests, career, and family. Activity plans are evaluated at least six-monthly at the same time as the review of the long-term care plan.</p> <p>Residents interviewed were extremely positive about the activity programme.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	FA	<p>Long-term care plans are evaluated by the RNs six-monthly or earlier if there was a change in resident health status. Evaluations are documented and identify progress to meeting goals.</p> <p>A six monthly multi-disciplinary review (MDR) is also completed by the registered nurse with input from HCAs, the GP, the diversional therapist, resident and family/whānau members and any other relevant person involved in the care of the resident. Care plan interventions are updated as necessary as a result of the evaluation. Activities plans are in place for each of the residents and these are also evaluated six-monthly.</p> <p>There are three-monthly reviews by the GP for all residents, which family are able to attend if they wish to do so. Short-term care plans are in use for acute and short-term issues. These are evaluated at regular intervals.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is</p>	FA	<p>Referral to other health and disability services is evident in the resident files sampled with the service facilitating access to other medical and non-medical services. The clinical manager interviewed could describe the procedure for when a resident's condition changes and the resident needs to be reassessed for a higher or different level of care. Discussion with the clinical manager and registered nurses identifies that the service has access to a wide range of support either through the GP, specialists, and allied health services as required.</p>

appropriately facilitated, or provided to meet consumer choice/needs.		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place. Material safety datasheets were readily accessible for staff. Chemical bottles sighted have correct manufacturer labels. Chemicals were stored safely throughout the facility. Personal protective clothing was available for staff and seen to be worn by staff when carrying out their duties on the day of audit. A spills kit is available.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>The building holds a current building warrant of fitness, which expires on 8 January 2022. A request book for repairs is maintained and signed off as repairs are completed. There is a part-time maintenance officer who, with oversight of the village manager carries out the monthly planned maintenance programme. The general manager is on call after hours for urgent matters. The checking and calibration of medical equipment including hoists, has been completed annually. All electrical equipment has been tested and tagged. Hot water temperatures have been tested (randomly) and recorded fortnightly with corrective actions for temperatures outside of the acceptable range. Preferred contractors are available 24/7.</p> <p>The care centre has two resident floors and a basement floor restricted to staff containing the laundry, waste management and maintenance area. The facility has stairs and an elevator that is able to accommodate an emergency service stretcher if required.</p> <p>The corridors are wide and promote safe mobility with the use of mobility aids and transferring equipment. Residents were observed moving freely around the areas with mobility aids, where required. There is outdoor furniture and seating with shade in place, and there is wheelchair access to all areas including internal paved courtyards with raised garden beds and a bush boardwalk.</p> <p>The healthcare assistants and RNs interviewed stated that they have all the equipment required to provide the care documented in the care plans.</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</p>	FA	<p>All resident rooms have a full ensuite. Handrails are appropriately placed in ensuite bathrooms and there is ample space to accommodate shower chairs and a hoist if appropriate. Privacy is assured with the use of ensuites. Fixtures, fittings, floorings, and wall coverings are good condition and are made from materials which allow for ease of cleaning. Hot water temperatures are monitored monthly and are within safe range as per current guidelines and legislation.</p>

privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	All resident's rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms. Staff interviewed reported that rooms have sufficient space to allow cares to take place. Residents are encouraged to bring their own pictures, photos, and furniture to personalise their room, as observed during the audit.
<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	There are large and small communal areas. There is a large main activities lounge, however activities occur in all areas of the facility, with residents being assisted to activities in different areas if they require it. There are sufficient lounges and private/quiet seating areas where residents who prefer quieter activities or visitors may sit. The dining areas are spacious, inviting, and appropriate for the needs of the residents.
<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	There are adequate policies and procedures to provide guidelines regarding the safe and efficient use of laundry services. The laundry has a dirty to clean workflow, two washers and two dryers. Dedicated laundry staff operate the service 7 days per week. All linen and personal clothing is laundered on site. The chemical provider monitors the effectiveness of the laundry process in addition the internal audits. Cleaning trolleys are kept in designated locked cupboards when not in use. Residents and family interviewed reported satisfaction with the cleaning and laundry service.
<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>There are policies and procedures on emergency and security situations including how services will be provided in health, civil defence, or other emergencies. All staff receive emergency training on orientation and ongoing. Civil defence supplies are readily available within the facility and include water, food, and supplies (torches, radio, and batteries), emergency power and barbeque. The facility keeps sufficient emergency water for 3 litres per person, per day for at least 3 days for resident use on site.</p> <p>There is an approved fire evacuation scheme in place and six-monthly fire drills have been completed. A resident building register is maintained. Fire safety is completed with new staff as</p>

		<p>part of the health and safety induction and is ongoing. All shifts have a current first aider on duty.</p> <p>Residents' rooms, ensuites, communal bathrooms and living areas all have call bells. Call bells and sensor mats when activated show on a display panel and also give an audible alert. Security policies and procedures are documented and implemented by staff. The buildings are secure at night, with external village gates being locked between 19.00 and 06.30. There is security lighting externally and CCTV covering entrances, exits and corridors.</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 bedrooms and communal areas have ample natural light and ventilation. The facility has under floor heating which is thermostatically controlled. Staff and residents interviewed, stated heating and ventilation within the facility is effective. There is a monitored outdoor area where residents may smoke. All other areas are smoke free.</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 infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Staff are well-informed about infection control practises and reporting. The infection control coordinator (clinical manager) is an RN who is responsible for infection control across the facility as detailed in the infection control coordinator job description (signed copy sighted on day of audit). The coordinator oversees infection control for the facility, reviews incidents on the electronic resident management system and is responsible for the collation of monthly infection events and reports. The facility management team are responsible for the development of, and annual review of the infection control programme.</p> <p>Hand sanitisers are appropriately placed throughout the facility. Visitors are asked not to visit if they are unwell. Residents are offered the influenza vaccine. There has been one outbreak since the last audit, which was well managed with appropriate referrals to, and input from public health and the DHB.</p> <p>Covid-19 education has been provided for all staff, including hand hygiene, donning/doffing and use of PPE. The service also conducted regular PPE and hand washing interactive demonstrations utilising 'Glo bug' gel to highlight the need for correct handwashing technique among staff members. Other pandemic readiness strategies included the recording of staff 'bubbles and documentation tracking dedicated staff allocations. Staff were observed to wipe down equipment (hoists, transfer belts) using sanitiser wipes between resident use.</p>

<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>There are adequate resources to implement the infection control programme at Patrick Ferry House. Information is shared as part of staff meetings and also as part of the registered nurse meetings (link 1.2.3.6). The infection control coordinator has completed annual training in infection control through the local DHB and sessions provided by external infection control specialists.</p> <p>External resources and support are available through an online learning portal, external specialists, microbiologist, GP, wound nurse and DHB when required. The pharmacy and clinical manager monitor the use of antibiotics. Overall effectiveness of the programme is monitored by the facility management team.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>The infection control policies include a comprehensive range of standards and guidelines including defined roles and responsibilities for the prevention of infection, and training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. The policies have been developed by the facility management team in conjunction with an external specialist.</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>The infection control coordinator is responsible for coordinating education and ensuring staff complete the online training available on the 'Ko Awatea' internet based DHB education system. Training on infection control is included in the orientation programme. Staff have completed online infection control study in the last 12 months. The infection control coordinator has also completed infection control audits. Resident education occurs as part of providing daily cares and as applicable at resident meetings.</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>Infection surveillance is an integral part of the infection control programme and is described in Patrick Ferry House's infection control manual. Monthly infection data is collected for all infections based on signs and symptoms of infection. Short-term care plans are used. Surveillance of all infections is entered onto a monthly infection summary. This data is monitored and evaluated monthly and annually. Outcomes and actions are discussed at staff meetings. If there is an</p>

that have been specified in the infection control programme.		<p>emergent issue, it is acted upon in a timely manner. Reports are easily accessible to the hospital manager. There have been two outbreaks since the previous audit, one in August 2016 and one in May 2017, and both were well managed.</p> <p>Surveillance is an integral part of the infection control programme and the purpose and methodology are described in the Patrick Ferry House surveillance policy. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility.</p> <p>Monthly infection data is collected for all infections based on standard definitions as described in the surveillance policy. Infection control data is monitored and evaluated monthly and annually. Trends are identified and analysed, and preventative measures put in place.</p> <p>Infections are entered into the electronic database to facilitate trend analysis. Corrective actions are established where trends are identified. The service also benchmarks with its sister facility.</p> <p>Systems in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There are policies and procedures around restraints and enablers. Three residents were using restraint (bedrails), and two residents were using enablers (bedrails) on the day of audit.</p> <p>Assessments were completed and written consent was provided by the resident or families for the restraints and by the three residents using enablers.</p> <p>Staff interviews confirmed their understanding of the differences between a restraint and an enabler. Staff receive regular training around restraint minimisation and the management of challenging behaviour that begins during their induction to the service.</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</p>	FA	<p>The clinical manager is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident representative, and medical practitioner.</p>

providers and others.		
<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>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the three restraint files sampled. The restraint coordinator, the resident and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments and consents were fully completed.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified, and approval processes are obtained/met. There is an assessment form/process that is completed for all restraints and enablers. The files reviewed had a completed assessment form and a care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were present in the files reviewed, appropriate interventions were in place to ensure resident safety and care needs are met. In resident files reviewed, appropriate documentation has been completed. The service has a restraint and enabler register, which is up updated each month.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.</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>	FA	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. Reviews are completed by the restraint coordinator. Any adverse outcomes are reported at the monthly staff meetings.</p>

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.2.3.6 Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.	PA Low	Data is collected on eCase. This includes collation of data around categories of incidents e.g. falls, challenging behaviour. The clinical manager, hospital manager and general manager state that they discuss the data. The hospital manager also states that this is discussed with registered nurses and staff at meetings. Staff and clinical (registered nurse) meetings do not include evidence of tabling of data or discussion of data that would lead to quality improvement.	Staff and clinical meetings do not evidence tabling of discussion of data with this leading to quality improvement.	Ensure that discussion around data is captured in meeting minutes with evidence that this leads to quality improvement. 90 days

Specific results for criterion where a continuous improvement has been recorded

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

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

If, instead of a table, 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.