Summerset Care Limited - Summerset Rototuna

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:	Summerset Care Limited
Premises audited:	Summerset Rototuna
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 21 September 2021 End date: 22 September 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: 35

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

Summerset Rototuna provides rest home and hospital (geriatric and medical) and dementia level care for up to 63 residents in the main care centre in addition to having 56 apartments certified for rest home level care. On the day of the audit there were 35 residents including two in the serviced apartments.

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

The village manager is appropriately qualified and experienced and is supported by a care centre manager who oversees the clinical services. There are quality systems and processes being implemented. Induction and in-service training programmes are in place to provide staff with appropriate knowledge and skills to deliver care. The residents and relatives interviewed spoke positively about the care and support provided.

This certification audit identified the service is meeting the health and disability services standards.

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.

The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code and related services are readily available to residents and families. Policies are available that support residents' rights. Cultural assessment is undertaken on admission and during the review process. Residents and family interviewed verified ongoing involvement with the community. Care plans accommodate the choices of residents and/or their family. Complaints processes are being addressed in line with HDC requirements.

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.		Standards applicable to this service fully attained.

Summerset Rototuna has established a quality and risk management system since opening. Key components of the quality management system link to a number of meetings including (but not limited to) monthly quality improvement meetings. Annual surveys and regular resident meetings provide residents and families with opportunities for feedback about the service. Quality performance is reported to staff at meetings and includes discussions relating to incidents, infections, and internal audit results. There are human resources policies that cover recruitment, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice. There is an in-service training programme covering relevant aspects of care. There is a staffing policy with safe staffing levels implemented.

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.

Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for each stage of provision of care including assessments, care plans and evaluations. Risk assessment tools and monitoring forms are available and implemented. Residents and family interviewed confirmed that they were happy with the care provided and the communication.

Planned activities are appropriate to the resident's assessed needs and abilities and residents advised satisfaction with the integrated activities programme. There are outings into the community and visiting entertainers.

There is a secure electronic medication system at the facility. There are medicine management policies that align with acceptable guidelines. Staff responsible for the administration of medications complete annual medication competencies and education. The general practitioner reviews the medication charts three monthly.

Residents' food preferences and dietary requirements are identified at admission and all meals are cooked on site. The kitchen is well equipped for the size of the service. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met. Nutritional snacks are available in the memory care (dementia) unit 24 hours a day.

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.

Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. The building holds a code of compliance. Resident rooms are spacious with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. There is an emergency plan in place including fire safety and there are sufficient civil defence supplies in the event of a civil emergency. Cleaning and laundry services are well monitored through the internal auditing system.

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 are documented policies and procedures around restraint use and use of enablers. During the audit, there was one resident using restraint and no residents using an enabler. Staff training around the use of restraint and enablers is provided. Restraint is only used as a last resort.

Infection prevention and control

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

The infection control programme is appropriate for the size and complexity of the service. The infection control coordinator (clinical nurse leader) is responsible for coordinating and providing education and training for staff. The infection control coordinator has attended external training. The infection control manual outlined the scope of the programme and included a comprehensive range of policies and guidelines. The infection control coordinator uses the information obtained through surveillance to determine infection control activities, resources and education needs within the facility. This included audits of the facility, hand hygiene and surveillance of infection control events and infections. The service engages in benchmarking with other Summerset facilities. There have been two outbreaks since the last audit that have been well managed and documented.

Covid 19 is well prepared for, education has been provided around donning and doffing personal protective equipment, isolation practices and hand washing. Adequate supplies of personal protective equipment were sighted.

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	50	0	0	0	0	0
Criteria	0	101	0	0	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	Discussions with twelve staff (three caregivers, two registered nurses (RNs), two diversional therapists, one head chef, one property manager, one laundry, one property assistant and one housekeeper) confirmed their familiarity with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and its application to their job role and responsibilities. Four residents (two rest home, and two hospital) and five relatives (two hospital, two dementia and one rest home) were interviewed confirming the services being provided are in line with the Code. Observations during the audit also confirmed this in practice.
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	The service has in place a policy for informed consent and resuscitation. Completed resuscitation treatment plan forms were evident on the six resident files reviewed (two hospital, two rest home including one resident from the serviced apartments and two residents in the memory care unit [dementia]). There was evidence that the general practitioner (GP) completed and signed clinically not indicated resuscitation status where residents were not deemed to be competent. Family discussions were evident in the whānau contact form and progress notes. General consent forms were evident on files reviewed. Discussions with staff confirmed that they are familiar with the requirements to obtain informed consent for personal care, entering rooms and so on. Signed admission agreements, enduring power of attorney and activation documentation was evident in the

		resident files reviewed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Residents are provided with a copy of the Code on entry to the service. Residents interviewed confirmed they are aware of their right to access independent advocacy services and advocacy pamphlets are available at reception. Discussions with relatives confirmed the service provided opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions. The resident files include information on residents' family/whānau and chosen social networks. There is a designated health advocate employed by the Health and Disability Advocacy Service available to any resident or family member, with contact details prominently displayed within the facility.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Visitors were observed coming and going during the audit. Interviews with staff, residents and relatives confirmed residents are supported and encouraged to remain involved in the community and external groups. Relatives and friends are encouraged to be involved with the service and care. The service promotes community visitors to the village and encourages resident involvement. Community links are primarily within the local area. Visitors to the facility include pet therapy, art therapy, local high school and kindergarten. There are various religious denominations actively involved with the facility.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The service has a complaints policy that describes the management of the complaints process. Complaints forms are readily available. Information about complaints is provided on admission. Interviews with residents and family members confirmed their understanding of the complaints process. There is an electronic complaint register that includes verbal and written complaints and evidence to confirm that complaints are being managed in a timely manner including acknowledgement, investigation, timelines, corrective actions (when required) and resolutions. One complaint had been received year to date (2021) with evidence of robust follow-up actions taken and feedback provided in staff meetings including corrective actions. Complainants are provided with information on how to access advocacy services through the Health and Disability Commissioner if resolution is not to their satisfaction.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	The service provides information to residents that include the Code, complaints and advocacy. Information is given to the family or the enduring power of attorney (EPOA) to read to and/or discuss with the resident. Residents and relatives interviewed confirmed that they were well informed about the Code. Informal, monthly resident meetings are held with the activities staff and the care centre manager, and there is access to an external advocate as required. These meetings provide the opportunity for residents to raise concerns. An annual residents/relatives survey is completed.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	Care staff interviewed were able to describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules and a code of conduct are signed by staff at commencement of employment. Contact details of spiritual/religious advisors are available. Residents and relatives interviewed reported that residents are able to choose to engage in activities and access community resources. There is an elder abuse and neglect policy. Staff education and training on abuse and neglect last occurred in July 2021 with 30 attending.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	Summerset has a Māori health plan that includes a description of how they achieve the requirements set out in the contract. There are supporting policies that provide recognition of Māori values and beliefs and identify culturally safe practices for Māori. At the time of the audit there were no residents that identified as Māori. Links are established with the Māori health advisor for the Waikato District Health Board (Ikimoki Tamaki-Takarei) and Te Kahoa Health, a local Māori health provider. Staff interviewed were able to describe how they can ensure they meet the cultural needs of residents.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	An initial care planning meeting is carried out where the resident and/or whānau as appropriate/able are invited to be involved. Individual beliefs and values are further discussed and incorporated into the care plan. Six monthly multi-disciplinary team meetings occur to assess if needs are being met. Family is invited to attend. Discussion with family/whānau confirms values and beliefs are considered. Residents interviewed confirm that staff take into account their culture and values.
Standard 1.1.7: Discrimination Consumers are free from any	FA	Staff job descriptions include responsibilities and staff sign a copy on employment. The monthly quality improvement meetings include discussions on professional boundaries and concerns as they arise. Management provides guidelines and mentoring for specific situations. Interviews with

discrimination, coercion, harassment, sexual, financial, or other exploitation.		managers and staff confirmed their awareness of professional boundaries.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	Residents and relatives interviewed spoke positively about the care and support provided. Staff have a sound understanding of principles of aged care and state that they feel supported by the village manager and care centre manager. All Summerset facilities have a master copy of policies which have been developed in line with current accepted best practice and are reviewed regularly. The content of policy and procedures are sufficiently detailed to allow effective implementation by staff. There is a quality improvement programme that includes performance monitoring against clinical indicators and benchmarking against like services within the Summerset group of aged care facilities. There is evidence of education being supported outside of the training plan. There are implemented competencies for caregivers and registered nurses including (but not limited to): insulin administration, medication, wound care and manual handling. Examples of quality initiatives currently in progress include a project addressing falls prevention and a focus on person centred care utilising aspects of the Spark of Life model of care.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	An open disclosure policy describes ways that information is provided to residents and families. The admission pack gives a comprehensive range of information regarding the scope of service provided to the resident and their family on entry to the service and any items they are to pay for that are not covered by the agreement. There is information specific to the memory loss (dementia unit) provided. Regular contact is maintained with family including if an incident or care/ health issue arises. Family members interviewed stated they were well informed. Thirteen incident/accident forms were reviewed, and all identified that the next of kin were contacted. There are monthly resident's meetings where any issues or concerns to residents are able to be discussed. Minutes are maintained and show follow-up actions for resolution of matters raised. The service has policies and procedures available for access to DHB interpreter services. The information pack is available in large print and can be read to residents. Non-Subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so.
Standard 1.2.1: Governance	FA	Summerset Rototuna opened 30 November 2020. The service provides rest home, hospital (geriatric and medical) and dementia level care for up to 119 residents. There are 43 dual-purpose rooms in

The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.		the care centre (including 8 double rooms) and 20 dementia level beds in the memory care unit. The secure dementia unit (Memory Care) are all LTO apartments with no standard rooms. There are also 56 serviced apartments certified for rest home level care. On the day of the audit there were 35 residents - 17 rest home level (including 2 serviced apartments),12 hospital level and 6 dementia level of care. All residents were under the aged residential care contract (ARCC) apart from one resident fully funded by ACC at hospital level of care. The overall management of the village is provided by a village manager who has over nineteen years of aged care experience. The care centre is managed by a care centre manager who has been employed by Summerset for over four years. She is assisted by a clinical nurse leader (CNL). There is a quality and risk management plan for 2021. The plan includes evidence of regular review of the facility's goals and objectives throughout the year. Quality is overseen by the organisation's regional quality manager who was available during the audit. The village manager and care centre manager have maintained greater than eight hours of professional development activities related to managing an aged care facility.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	During the temporary absence of the care centre manager, the CNL provides clinical leadership/oversight, and the village manager is delegated operational responsibilities. The regional operations manager and the regional quality manager provide oversight and support.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	An annual quality and risk management plan is in place. Policies and procedures reflect evidence of regular reviews as per the document control schedule. New and/or revised policies are made available for staff to read and sign that they have read and understand the changes. Village managers and care centre managers are held accountable for their implementation. The monthly collating of quality and risk data includes (but is not limited to) residents' falls, bruising, skin tears and infection rates. Data is collated and benchmarked against other Summerset facilities to identify trends. A resident satisfaction survey is conducted each year, the first survey just having been completed 10th September. The results of the survey were not yet available at the time of audit. An annual internal audit schedule was sighted for the service. Corrective actions are developed where opportunities for improvements are identified and are signed off when completed. Staff are kept

		informed of audit findings and quality initiatives, evidenced in the range of meeting minutes (e.g., quality, RN, caregiver). There is a health and safety team who meet monthly. Data relating to health and safety is entered into the electronic Risk Management Support System (RMSS). Hazard identification forms and a hazard register (reviewed June 2021) are in place. Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by-case basis to minimise future falls. Falls prevention strategies include the use of sensor mats, sensor lights that turn on the bathroom light in the dementia unit,
Standard 1.2.4: Adverse Event Reporting 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.	FA	The service collects a comprehensive set of data relating to adverse, unplanned and untoward events. This includes the collection of incident and accident (events) information. The reporting system is integrated into the quality and risk management programme. Fourteen incident reports, held electronically, were sampled (six medication errors, six resident behaviour issues, one unwitnessed fall and one infection). All fourteen events sampled evidenced clinical follow up. Adverse events are reviewed and investigated by the care centre manager. If risks are identified these are processed as hazards. Discussions with the village and care centre managers have confirmed their awareness of statutory requirements in relation to essential notification. Section 31 notifications since the previous audit have included three instances of threatening behaviour, change of village manager and change of clinical nurse leader. The public health team were notified in a timely manner of the two outbreaks.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	There are job descriptions available for all relevant positions that describe staff roles, responsibilities and accountabilities. The practising certificates of nurses were current. The service also maintains copies of other visiting practitioners practising certificates including GP, pharmacist and physiotherapist. Eight staff files were reviewed (two caregivers, two RNs including CNL, one diversional therapist, one chef manager, care centre manager and one laundry). Evidence of signed employment contracts, job descriptions, completed orientation that is specific to their job duties, and attendance at greater than eight hours of education and training annually were sighted. Annual performance appraisals for staff are conducted. Interviews with the care centre manager and caregivers confirmed that the orientation programme includes a period of supervision. The service has a training policy and schedule for in-service education. The in-service schedule is

		implemented, and attendance is recorded. Caregivers undertake Careerforce education and to date eleven have achieved level 4, one level 3, two level 2 and six have started on the qualification pathway at level 0. There are five registered nurses, three are InterRAI trained. There are implemented competencies for registered nurses including (but not limited to); medication, restraint, syringe driver and insulin administration.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. At the time of the audit there were 35 residents (6 dementia level, 12 hospital level and 17 rest home level, including 2 in serviced apartments). The care centre manager is rostered Monday – Friday. She is supported by two RNs on the AM shift plus the clinical nurse lead (CNL), one RN on the PM shift, and one RN on the night shift. For hospital and rest home level care, five caregivers are rostered on the AM shift (four long shifts and one short shift). Four caregivers are also rostered on the PM shift, three long and one short shift (one covers the apartments) and two caregivers are rostered on the night shift. With any increase in resident numbers and/or an increase in resident acuity, short shift caregivers have the flexibility to have their shifts extended. Additionally, for the memory care unit there is a full shift caregiver rostered for the AM, the PM and night shift. The memory care unit also has its own diversional therapy hours between 09.00-18.00 seven days per week.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files were 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. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Resident files are protected from unauthorised access. Care plans and progress notes are documented electronically. Resident files demonstrate service integration.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent,	FA	Summerset at Rototuna have comprehensive admission policies and procedures in place to safely guide service provision and entry to services. Referring agencies establish the appropriate level of care required prior to admission of a resident. Prospective residents are screened by the care centre manager and the clinical nurse lead. The service has a well-developed information pack available for

equitable, timely, and respectful manner, when their need for services has been identified.		residents/families/whānau at entry outlining services able to be provided, the admission process and entry to the service. Information provided to families include information around dementia in line with the ARRC contract. Information gathered at admission is retained in resident's records. All six admission agreements viewed were signed. Exclusions from the service are included in the admission agreement. Residents and relatives interviewed stated they were well informed upon admission and had the opportunity to discuss the admission agreement with the manager.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. Planned exits, discharges or transfers are coordinated in collaboration with the resident and family to ensure continuity of care. Copies of documentation and handover is kept on file as evidenced in one resident file that was transferred to hospital following a fall.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	There are medicine management policies and procedures that align with recognised standards and guidelines for safe medicine management practice. The RNs are responsible for the administration of medications and have completed medication competencies and annual medication education. Senior caregivers have competencies for second checkers in in the absence of a second registered nurse (afternoon and night). The RNs have completed syringe driver training. All medications and robotic rolls were evidenced to be checked on delivery with any discrepancies fed back to the supplying pharmacy. Standing orders are not used by the service. There was one self-medicating resident (rest home) on the day of the audit. The resident had and assessment and competency signed by the resident, RN and GP, this is due to be reviewed in three months. All medications were stored securely in the locked medication room in the care centre. The medication room is secure and fitted out in the memory care unit. Due to the low number of residents, this is not yet in use. The care centre RN administers medication in the memory care unit at present. Original labels were present on medication in the medication trolley and cupboards. Eyedrops had open dates documented. The medication fridge temperature was not monitored and recorded regularly. Twelve electronic resident medication charts (four hospital, four rest home and four from the memory care unit) were reviewed on the electronic medication system. All electronic charts had a photo ID and allergy status documented. The 'as required' medications had an indication for use, effectiveness was documented in the progress notes. Incident reports were completed for medication errors, and corrective actions were implemented, reviewed and signed off for non-conformities identified during

		internal audits.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	Summerset has comprehensive nutritional management policies and procedures for the provision of food services for residents. There is a chef manager, three chefs, three kitchen assistants, one café supervisor and two café assistants employed who provide all aspects of the food service. All food services staff have completed food safety training. A current food control plan in in place. All food and baking are freshly prepared in the large purpose-built kitchen on the ground floor adjacent to the café and dining area of the village residents. There is a walk-in chiller, and freezer. Temperatures are recorded twice daily electronically on an app. All decanted food in the walk-in pantry has been dated. The 12-week seasonal menu is designed and reviewed by a registered dietitian. Food is transported in hot boxes to the satellite kitchen in the main dining room of the care centre on level one, to the satellite kitchen/dining area of the rest home residents in serviced apartments, and the memory care unit kitchenette. Meals are served to residents from the hot boxes in the satellite kitchen by staff. There is a lift near the service area, that is used to transport food carriers to each floor and dishes back to the kitchen. All residents are required to have a nutritional profile completed on admission, which is provided to the kitchen. There is access to a community dietitian. There is a whiteboard in the kitchen to alert staff of residents' dislikes. Special diets including gluten free, textured diets and diabetic diets are accommodated for. Feedback is gained through the satisfaction survey (2021 results not yet available), and verbal feedback when serving food in the dining rooms. The head chef interviewed was aware of residents with special diets and who are losing weight unintentionally. The main meal is served at lunchtime with a light option in the evening. Alternatives are available if required. Snacks are available in the care centre for residents when the kitchen is closed. Extra snacks are available in the fridge in the kitchenette in the memory care unit 24/7. There is an induction hob in the kitchenette of the memory care unit and dual-purpose units that prevent any resident burning themselves if touched. Boiling water taps have a safety mechanism.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the	FA	The service records the reason for declining service entry to potential residents should this occurs and communicates this decision to the potential residents/family/whānau and the referring agency. The reasons for declining entry would be if the service is unable to provide the assessed level of care or there are no beds available. Potential residents would be referred back to the referring agency for appropriate placement and advice.

organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The long-term resident files sampled evidenced that residents are admitted with a care needs level assessment completed by the Needs Assessment and Service Coordination (NASC) team prior to admission. Files sampled indicated that personal needs information is gathered during admission from discharge summaries, medical notes, home care assessments and from discussions with the resident and their relative where appropriate. The interRAI assessment tool was utilised as part of the six-monthly care plan updates. Additional risk assessments for skin integrity, continence and pain, etc, are completed on admission and reviewed six-monthly or when there is a change in a resident's condition. The electronic resident management system implemented by the service provides a suite of assessments for RNs to utilise as appropriate. Outcomes of the assessments were reflected in the long- term care plans.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Five of the six (one was a respite admission) resident long-term care plans were reviewed. The long-term care plans, completed within three weeks, records the resident's problem/need and objectives, all had sufficient interventions that reflected the residents' current needs. Residents and families interviewed confirmed their involvement in the care planning process. The resident or the family member sign the long-term care plan acknowledgement document as sighted in the resident files. Short-term care plans were evident in use for short-term needs including (but not limited to): wounds, infections and skin conditions and increasing behaviour, and changes in health status. These were reviewed regularly and signed off as resolved or if an ongoing problem, added to the care plan. Resident files demonstrated service integration and evidence of allied health care professionals involved in the care of the resident such as referral to mental health team dietitian, and physiotherapist.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition alters, the registered nurse initiates a review and if required a GP or nurse specialist consultation. Evidence is present of family members being notified of any changes to their relative's health status, incidents and updates. Discussions with families and notifications were documented on the family/whānau contact sheet in the resident files. Interviews with residents and family confirmed that their relative's needs are met, and they are kept informed of any health changes. Adequate dressing supplies were sighted in the treatment rooms. The wound care file was reviewed. Electronic wound assessments, treatment and evaluations were in place for all three current wounds (skin tear, graze and chronic wound). There were no pressure injuries on the day of audit. The RNs interviewed were able to describe the referral process for a wound care nurse specialist if required. Short-term care plans are used for short-term needs and were sighted for wounds, skin tear and skin

		infection. Staff interviewed were aware of residents' needs and understood interventions on how to meet them. Continence products are available and resident files include a urinary continence assessment, bowel management, and continence products identified. Staff interviewed stated that they have enough stock available and are aware of how to access stock if need arises. Sufficient gloves and aprons were available and sighted for staff to utilise. A suite of electronic monitoring charts are available to monitor resident health and progress against implemented interventions including (but not limited to) behaviour, weight, wounds, blood sugar monitoring, neurological observations, food, fluid, pain, turning charts and vital signs.
Standard 1.3.7: Planned Activities 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.	FA	Summerset at Rototuna employ two diversional therapists. One is based on the memory care unit and the other is based in the care centre. Both have current first aid certificates and attended the diversional therapist conference earlier in 2021. Each resident has an activities assessment completed which forms the basis of the individual activities plan and the 24-hour activity plan for residents in the memory care unit. The diversional therapists maintain attendance records daily and document progress notes weekly. Activities in the care centre run over Sunday to Friday starting at 9.30am with daily exercises, and finish at 4pm. There is a full range of social activities that are available on the monthly programme for all residents to participate in. activities include (but are not limited to); arts and crafts, quiz, crosswords are completed along with morning tea, cultural days, movies, celebrations for Alzheimer's day, daffodil day, and the like. There are ladies and mens' groups, coffee groups growing. One-on-one contact is made daily with residents who are unable to or choose not to participate in group activities. The service has implemented a new initiative of a wishing tree. The tree is painted onto a wall in the activity lounge in the care centre. Residents make a wish on a leaf, and when the wish comes true, the wish turns into a flower. The diversional therapist takes photos of the wish coming true. One example was of a resident who wished to go fishing. Due to a deterioration in health, the resident was unable to go fishing, there was a fish (newly caught) brought into the facility, where it was prepared and cooked with chips and shared. The family and the team decorated the lounge with fishing attire, and photos were taken of the wish coming true for that resident. Activities in the memory care unit run over Monday to Friday with the care staff assisting with activities over the weekend. The monthly programme is very flexible in the memory care unit and activities are often spontaneous, depending on the resident's mood and the weather on the day. Activities include word games, art and crafts, group games, baking daily exercises. The service utilises the Tovotaffle

		sensory table, for sensory activities, the diversional therapist uses this in the afternoons as a calming activity for residents. Both units have high school children attend, who are currently assisting residents with wearable arts costumes. A range of community groups and volunteers visit the facility including pet therapy, an art therapist, church services are held. Van outings are provided for residents. The diversional therapists are liaising with preschools to visit. During the recent lockdown, residents in the memory care unit remained as one 'bubble' with the majority of residents in the care centre staying in their rooms, activities were held in corridors, daily exercises continued with residents socially distancing in line with the guidelines, increased one on one sessions were held in individual resident rooms, such as general chats, newspaper reading, bible reading and massages. Resident meetings are held which discuss all aspects of the service. Residents interviewed felt comfortable providing feedback of the service. The head chef attends when required to discuss food services. A recent satisfaction survey has been held. results were unavailable at the time of the audit. The residents and relatives interviewed stated they were satisfied with the variety of activities on offer, and residents attend activities of their particular liking.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	There is evidence of resident and family involvement in the evaluation of resident care plans. Initial care plans and long-term care plans were evaluated by the registered nurses. Written evaluations had been completed six-monthly or earlier for resident health changes for the residents who have been in the facility for more than six months. Families are invited to attend the review and asked for input if they are unable to attend. Short-term care plans sighted have been evaluated by the RN as sighted in the resident's files. Care plan evaluations document resident progression towards meeting goals, and care plan interventions were updated accordingly.
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	FA	Referral to other health and disability services is evident in the resident files sampled. Mental health services for older people, podiatrist, speech and language therapy and physiotherapy are some of the allied services accessed by resident referrals in consultation with GP. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Residents/EPOAs are informed and involved in the referral process. The GP refers residents to medical specialists when required.

to meet consumer choice/needs.		
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented policies and procedures for waste disposal and chemical storage. The policies document procedures for the safe and appropriate storage, management, use and control and disposal of waste and hazardous substances. Chemicals are automatically dispensed in the laundry. There are two key padded sluice rooms, one in the dual-purpose unit and one in the memory care unit. All housekeeping and laundry staff have completed waste management training and personal protective equipment (PPE) at orientation. Gloves, aprons, and disposable visors are readily available in the sluice rooms, cleaners' cupboards and laundry. Staff interviewed were knowledgeable around waste management procedures.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The care centre is a three-level facility. The ground floor includes nine serviced care apartments, service areas and a secure dementia unit. The memory care unit are all LTO apartments. Level one includes 43 rooms (all dual-purpose hospital/rest home rooms). Eight of the 43 rooms have been verified as suitable as double rooms for couples if needed, which potentially could be up to 51 residents. There are also 19 serviced apartments on level one. Level two includes 28 serviced apartments. All 56 serviced apartments can provide rest home level care. The building holds a current CPU certificate which was issued on 26 November 2020. There is a maintenance person employed for 40 hours a week, working from Monday to Friday and available on call, after hours and on weekends. The Summerset planned maintenance programme is in place to address reactive and preventative maintenance. All medical and electrical equipment was purchased new and is less than a year old. The recently employed property manager is liaising with external contractors to ensure all equipment is tagged tested and calibrated when due. All equipment is stored in the centrally located equipment rooms in the care centre. Staff stated they have sufficient equipment to safely deliver care to meet resident needs. Hot water temperatures in resident areas have been regularly monitored and recorded. Water temperature checks were within expected ranges. The property manager describes corrective actions required and plumber availability should the water temperatures fall outside of the expected range. Hallways are very wide with seating areas. The facility has enough space for residents to mobilise using mobility aids and residents are observed moving around freely. There is a large lift (suitable for beds) and another smaller lift to transport residents and relatives between floors. The external areas and gardens are well maintained. The facility is built around a central courtyard.

		Residents in the memory care unit have easy access to the internal courtyard that has been landscaped with winding paths, raised flower beds and areas of interest. Seating with shade is provided. The memory loss unit is secure. Visitors have speaker access to staff and then the door will be released to enter the entrance foyer. There is a glass door from the foyer into the unit which will be opened by staff for visitors to enter, which has frosting on the glass to draw residents' attention away from the door. All exits in and out require swipe card access by staff. Decals are used around the corridors to distract residents from locked rooms, dead end walls and doors. Contrasting colours in some areas such as ensuites provide easier visibility and identification of furniture. There are large, coloured wall boxes outside each resident room that can be personally decorated. Each resident room entrance door has a different panel. The care centre has a centrally located 'conservatory' area, with access to balcony areas. Seven care suites have individual balcony spaces. Communal areas have balcony spaces for residents to enjoy. There is also a family room available for residents and families to utilise. Residents have access to designated external areas that have seating and shade. The service has two vehicles (a car and bus) to provide transport to residents and for staff usage. Both vehicles have current vehicle warrants of fitness and registration documents as evidenced.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	All resident rooms have full ensuite facilities with a shower. There are mobility toilets located near all lounges with locks that can be opened from the outside if needed. There are separate staff and visitor toilets. There are picture signs for residents in the memory care unit to assist with locating the toilet. Doors into the ensuites in the memory care unit are different colours, and the toilet seats are coloured.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Residents' rooms are spacious and allow care to be provided and for the safe use and manoeuvring of mobility aids. Mobility aids can be managed in ensuites and communal toilets and bathrooms. Double rooms are large enough for two beds and limited mobility equipment. The centre manager reports the double rooms would be used for rest home level care residents; hospital level residents would be able to use the room with limited use of equipment. The apartments in the memory care unit and the serviced apartments all have a separate lounge and bedroom.

		The resident suites in the memory care unit have sensors which turn on the ensuite light when activated during the night. The kitchen areas in the memory care units have a fridge freezer, cutlery and crockery. A kettle for making hot drinks can be available if the resident is deemed safe to use this. There are no cooking facilities in the memory care unit apartments. The care suites in the care centre have kitchenette areas.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a café, dining room and large lounge area adjacent to the apartments on the ground floor. This is available for village residents, visitors and any care centre residents that choose to go to the café. There is also another lounge/dining area for serviced apartment rest home residents on level one. There is a separate dining room and kitchenette on one side of the memory care unit. On the other side of the memory care unit there is a spacious activity room and lounge. There is also a separate family room/sensory room off the lounge. On level one (dual-purpose unit), there is a large spacious living area and kitchenette/dining area. There is a separate recreation area off the lounge. There is also a large spacious conservatory area and covered balcony. A separate family room is also available. There are other areas available for sitting and resting throughout the facility.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are policies for cleaning and infection prevention and linen handling and processing. These policies ensure that all cleaning and laundry services are maintained and functional at all times. All chemicals are within a closed system. Material safety datasheets are provided by the contracted company and to be displayed in the cleaning cupboards, laundry and sluices in each area. The laundry and cleaning areas have hand-washing facilities. There are personal laundries in the serviced apartments on each floor. All chemicals are stored securely in locked cupboards. There are designated laundry and housekeeping staff employed to provide services across seven days a week. The facility laundry is on the ground floor and has an entrance for dirty laundry and an exit for clean. The laundry is large and includes two commercial washing machines and two dryers. Dirty linen can be transported to the ground floor via a laundry chute from level one to the laundry. There are covered laundry trolleys in the units with colour coded linen bags. The laundry assistant interviewed was knowledgeable around laundry processes, infection control practices and keeps laundry form each unit separated. There are documented systems for monitoring the effectiveness and compliance with the service policies and procedures. Laundry and cleaning audits are completed with corrective actions

		documented for any non-conformities. There are designated locked cleaning trolleys on each floor. All housekeeping and laundry staff have completed chemical safety training. Housekeeping trolleys have locked boxes to store chemicals. Housekeeping staff were noted to be wearing PPE when attending to their duties. The housekeeper interviewed easily described cleaning schedules and infection control practices during lockdown periods and during internal outbreaks.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an emergency and civil defence plan to guide staff in managing emergencies and disasters. Emergencies and first aid are included in the mandatory in-service programme. There is a first aid trained staff member on every shift. Summerset Rototuna has an approved fire evacuation plan and fire dills occur six-monthly, the most recent took place 25 May 2021. Smoke alarms, sprinkler system and exit signs are in place. The service has alternative cooking facilities (barbeque) available in the event of a power failure. There are five 1000 litre tanks and stored bottled water for use in an emergency. The service holds at least three days of food storage. Emergency power is used for lighting and calls bells for up to two hours with torches readily available and solar lights that can be accessed from the garden areas. The site has its own generator in case of power outage with the emergency water pumps connected directly to this power source. Call bells were evident in resident's rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	General living areas and resident rooms are appropriately heated and ventilated. Resident's rooms throughout the facility have air conditioning units. The communal living areas are heated and cooled via ceiling heating/cooling systems. All rooms have floor to ceiling external windows with plenty of natural sunlight. All windows are double-glazed, and all areas have good lighting. Resident suites in the memory care unit rooms have individual resident room lighting which can be controlled by staff from controls outside each room. Some rooms in the care centre have individual Juliette balconies.
Standard 3.1: Infection control management There is a managed environment, which minimises the risk of infection to consumers, service	FA	The infection control programme is appropriate for the size and complexity of the service. There is an infection control responsibility policy that includes responsibilities for the infection control officer who is the clinical nurse lead. The infection control officer has a signed job description. The infection control programme is linked into the quality management system and reviewed annually. Goals for 2021 include (but are not limited to), reducing urinary tract infections, keeping the facility Covid free, continuing with surveillance and monitoring of infections. There is a monthly "zoom" meeting with the

providers, and visitors. This shall be appropriate to the size and scope of the service.		infection control quality manager and all infection control officers. Facility meetings include a discussion of infection control matters. Visitors are asked not to visit if they are unwell. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility. There have been two outbreaks, one gastroenteritis in March 2021 and a recent RSV outbreak. Both were well documented, with logs maintained. Notifications were made in a timely manner and relatives were informed. Debrief meetings were held. Covid 19 is well prepared for. All visitors and contractors are required to sign in using the electronic system, which includes wellness checks. All staff, visitors and contractors were required to wear masks and use hand sanitiser in line with current (level 2) Covid requirements. All staff have been trained in donning and doffing personal protective equipment (PPE), isolation and standard precautions. Adequate supplies of PPE were sighted in the infection control cupboard. Monthly stocktakes are completed to ensure adequate supplies are available.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control officer has been in the role at Summerset at Rototuna for three months. She has recently an on-line Summerset infection control course and anther through the Waikato DHB online education platform. The monthly “zoom” meetings with all Summerset infection control officers includes topical infection control. The infection control committee is representative of the facility. The infection control team meet monthly and provide a report to the quality improvement meeting, facility meetings and infection control quality manager at head office. The infection control officer has access to an infection control nurse specialist at the DHB, GPs, laboratory, pharmacy and expertise within the organisation.
Standard 3.3: Policies and procedures 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.	FA	Policies and procedures are developed and reviewed at head office and include Covid 19 policies and procedures. Policies are available to all staff. They are notified of any new/reviewed policies and are required to read and sign for these. There are Covid 19 flip charts available in the nurses’ station to guide staff through the Covid19 lockdown levels and requirements.

These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.		
Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	The infection control officer is responsible for coordinating and providing education and training to staff. The orientation package includes specific training around handwashing competencies and standard precautions. Ongoing training occurs six-monthly as part of the training calendar set at head office. Education for 2021 to date includes isolation procedures, outbreak management, and hand hygiene spot checks. Resident education occurs as part of providing daily cares. Care plans can include ways to assist staff in ensuring this occurs.
Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.	FA	The infection control policy includes a surveillance policy that includes a surveillance procedure, process for detection of infection, infections under surveillance, outbreaks and quality and risk management. Infection events are collected monthly and entered into the electronic system. The infection control officer provides infection control data, trends and relevant information to the infection control committee and clinical/quality meetings. Areas for improvement are identified, corrective actions developed and followed up. The facility is benchmarked against other Summerset facilities of similar size and benchmarking results are fed back to the infection control officer and used to identify areas for improvement. Infection control audits across all services are completed and corrective actions are signed off (sighted). Surveillance results are used to identify infection control activities and education needs within the facility. Reports and graphs are displayed on the staff room infection control noticeboard.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	There are documented policies and procedures around restraint use and use of enablers. During the audit, there was one resident using restraint and no residents using an enabler. Staff training around the use of restraint and enablers is provided. Restraint is only used as a last resort.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes	FA	A restraint approval process and a job description for the restraint coordinator are in place. The restraint coordinator role is delegated to a registered nurse. They have been in this role for two months. All staff are required to attend restraint minimisation training annually.

(including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Only registered nursing staff can assess the need for restraint. Restraint assessments are based on information in the resident's care plan, discussions with the resident and family and observations by staff. The restraint assessment tool meets the requirements of the standard. The resident's file where restraint was being used was reviewed. The file included a restraint assessment and consent form that was signed by the resident's family. Restraint use is linked to the resident's care plan and is regularly reviewed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	A restraint register is in place. This register identifies the residents that are using a restraint, and the type(s) of restraint used. The restraint assessment identified that restraint is being used only as a last resort. The restraint assessment and on-going evaluation of restraint use includes reviewing the frequency of monitoring residents while on restraint. Monitoring forms are completed when the restraint is put on and when it is taken off and indicate monitoring at the frequency described in each resident's care plan.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is reviewed monthly by the restraint coordinator, during restraint meetings and three-monthly by the GP. The review process includes discussing whether continued use of restraint is indicated.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The restraint programme, including reviewing policies and procedures and staff education, is evaluated annually by the Summerset head office.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.