

# Phantom 2021 Limited - Ashlea Grove Rest Home

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## Introduction

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

The audit has been conducted by 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:** Phantom 2021 Limited

**Premises audited:** Ashlea Grove Rest Home

**Services audited:** Rest home care (excluding dementia care); Dementia care

**Dates of audit:** Start date: 2 December 2021      End date: 3 December 2021

**Proposed changes to current services (if any):** The provisional audit was completed to assess the suitability and preparedness of the prospective owners. The intended date of purchase is 15 December 2021.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 27

# Executive summary of the audit

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## 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.

## General overview of the audit

Ashlea Grove Rest Home is a family-owned facility and is certified to provide rest home and dementia level care for up to 37 residents. On the day of audit there were 27 residents.

This provisional audit was completed to assess the suitability and preparedness of the prospective new owners. The provisional audit was conducted against the health and disability services standards and the contract with the district health board. The audit process included the review of existing policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, GP, staff, managers, and prospective owners.

Several environmental changes have been completed and include internal refurbishment and upgrade of several outdoor spaces.

Two managers (husband and wife) have managed Ashlea Grove Rest Home since 2015. They are responsible for the non-clinical management of the daily operations, as well as finance and maintenance. They are supported by a part time clinical lead who is a registered nurse, another part time registered nurse and experienced staff.

The current managers are also the prospective new sole owners of Ashlea Grove Rest Home. They partly own another three facilities in the region and another care facility in Christchurch. Both of the prospective owners have experience in aged care management and working with residents with dementia. It is intended that one of the prospective owners will take over the facility manager's role at Ashley Grove Rest Home. A transition plan has been developed to ensure a smooth transition of business functions. The prospective owners stated that their governance and quality management system, and policies and procedures will remain unchanged. There will be no changes to the existing staff and rosters.

Residents and family members interviewed are complimentary of the services provided.

This audit identified no areas for improvement.

## **Consumer rights**

Ashlea Grove Rest Home provides an environment that supports resident rights. Staff demonstrated an understanding of residents' rights and obligations. Residents receive services in a manner that considers their dignity, privacy, and independence. Written information regarding consumers' rights is provided to residents and relatives. There is evidence that residents and relatives are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected, and upheld by the service. Care plans accommodate the choices of residents and/or their family/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

## **Organisational management**

Ashlea Grove has fully implemented its quality and risk management system. There are policies and procedures to provide appropriate support and care to residents with rest home and dementia level needs. Services are planned, coordinated, and are appropriate to the needs of the residents. Quality goals are documented for the service. A risk management programme is in place, which includes incident and accident reporting, and health and safety processes. Adverse, unplanned, and untoward events are well documented by staff.

Human resources are managed in accordance with good employment practice. An orientation programme and ongoing training is provided and the training plan for 2020 has been implemented and ongoing and on schedule for 2021. Rosters and interviews indicated sufficient staff that are appropriately skilled with flexibility of staffing around resident needs.

## **Continuum of service delivery**

All assessments are completed using a series of assessments and interRAI. All residents are assessed prior to entry to the service with baseline assessments completed upon admission. There is evidence of input from the resident/family/whānau in the service delivery. Resident/family/whānau interviewed confirmed that they were happy with the care provided and the communication. Care plans are resident focused and have clearly identified goals. The files sampled identified integration of allied health with a team approach evident in the resident file. Resident/family/whānau interviewed expressed satisfaction with the activities provided and meet the residents' assessed needs and abilities.

There is an electronic medication management system at the facility with a three-monthly general practitioner review. Food preferences and dietary requirements are assessed at admission with all resident food prepared and cooked on site. Food, fluid, and nutritional needs of residents are provided and meet the nutritional guidelines. There are modified diets needs available as assessed by the dietitian. The kitchen has adequate equipment and has a registered food control plan.

## **Safe and appropriate environment**

There are specific policies and procedures for cleaning and laundry services, they are monitored through the internal auditing system. Chemicals are stored securely and there are safety data sheets available. Appropriate policies are available along with product safety charts. There is a current building warrant of fitness.

There are a variety of room types including rooms with their own toilet/handbasin, others with a handbasin and some without. There is wheelchair access to all areas. There are external areas which are safe and well maintained. Fixtures, fittings, and

flooring is appropriate and toilet/shower facilities are adequate. There is an emergency plan including fire safety and in the event of an emergency there is enough civil defence equipment.

## **Restraint minimisation and safe practice**

Ashlea Grove actively minimises the use of restraint. All staff receive training on restraint minimisation and management of behaviours that challenge. At the time of the audit there were no residents using restraint or enablers.

## **Infection prevention and control**

Infection control is led by the registered nurse, who is supported by representation from all areas of the service. The infection control policy identifies the role of the infection control nurse.

The infection control programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the infection control coordinator, and the quality/management team. Staff are informed about infection control practises through meetings, training and information posted on staff noticeboards.

Surveillance of infections is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. Covid-19 prevention strategies have been implemented to screen visitors and is integrated as part of the overall infection control policies. The residents, relatives and staff interviewed were knowledgeable around the recent changes and requirements as a result of Covid-19.

## 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)
<b>Standards</b>	0	45	0	0	0	0	0
<b>Criteria</b>	0	93	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)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Ashlea Grove ensures that all residents and families are informed about the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code). There is a poster displayed in a visible location. Policies around the Code are implemented, and staff could describe how the Code is incorporated in their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues through in-service education and training. Interviews with eight staff (one registered nurse [RN], four caregivers [working across both units], one diversional therapist, one cook, and one cleaner) and three managers (one clinical lead, one facility manager, one operations manager) reflected their understanding of the key principles of the Code.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with the information they need to make</p>	FA	<p>Six admission agreements were reviewed. The agreements included written general and specific consents signed by either the resident or their Enduring Power of Attorney (EPOA) at the time of admission. The residents and relatives interviewed confirmed informed consent was</p>

<p>informed choices and give informed consent.</p>		<p>discussed at the time of admission and carers sought consent when undertaking cares. Residents/family/whānau also commented they are involved in the development of care plans. Resident 'Do Not Resuscitate' (DNR) forms were signed by the resident if competent or there was a documented discussion in the care plan; this was confirmed by the general practitioner (GP). Advanced care plans have been completed for the six resident files reviewed.</p> <p>Informed consent is signed by each EPOA for residents sharing a room.</p> <p>Three files reviewed in the dementia unit had an admission documentation signed and completed by the EPOA and a copy of the activated EPOA is on the file.</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>	<p>FA</p>	<p>Residents and/or relatives are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet on admission. The complaints process includes the complainant to be informed of their right to access an independent advocate. Interviews with relatives confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main corridor. Advocacy is regularly discussed at resident/relatives' meetings (minutes sighted).</p> <p>The service provides opportunities for the family/EPOA to be involved in decisions. The resident files sampled included information on the resident's family and chosen social networks.</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>	<p>FA</p>	<p>Interview with relatives confirmed that visiting can occur at any time and families are encouraged to be involved with the service and care. Residents are supported to maintain former activities and interests in the community if appropriate. The younger person with disabilities (YPD) interviewed stated support is provided to attend a local men's group. Activities include outings and visitors/entertainers to the facility. Various volunteers ensure the facility remains connected with the immediate area.</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>	<p>FA</p>	<p>Ashlea Grove has a complaints policy and procedure in place, which residents and their family/whānau are provided with on admission. The aim is to provide a safe and open environment where all compliments, concerns and complaints are welcomed as opportunities for improvement. Complaint forms are available at the entrance of the service. Staff are aware of the complaints process and to whom they should direct complaints. The manager maintains a record of all complaints, both verbal and written, by using a complaint register.</p> <p>A review of the complaint log/register evidenced that Ashlea Grove Rest Home received no complaints from July 2020 year to date. Documentation including follow-up letters and resolution, demonstrated that previous complaints had been managed in accordance with guidelines set by the Health and Disability Commissioner. Meeting minutes evidenced complaints (if received) are part of the agenda discussions.</p> <p>Residents and relatives advised that they are aware of the complaints procedure and how to access complaint forms.</p> <p>There have not been any complaints from external providers or authorities since the last audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>Details relating to the Code are included in the resident information pack that is provided to new residents and their relatives/enduring power of attorney (EPOA). This information is also available at the entrance to the facility. The registered nurses discuss aspects of the Code with residents and their relatives on admission. The caregivers interviewed were knowledgeable around all aspects of the Code and described how they incorporate this into practice.</p> <p>Discussions relating to the Code are held during the resident meetings. The five rest home residents and two relatives (two from dementia) interviewed, reported that the service is upholding the residents' rights.</p> <p>The interview with the prospective owners confirmed that they were able to describe the application of consumer rights.</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>	<p>FA</p>	<p>Residents are treated with dignity and respect, positive and respectful interactions between staff and residents were witnessed throughout the audit. Staff were observed knocking on resident doors and waiting to be invited into the residents' rooms. Residents and relatives interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy is ensured and independence is encouraged. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with relatives' involvement and is integrated into the residents' care plans. Spiritual needs are identified, and church services are held. There is a policy on abuse and neglect and staff have received training in September 2021. Caregivers interviewed who work in the dementia unit could fluently describe changes in resident behaviour which may be caused by different forms of abuse. Residents interviewed stated they are encouraged by staff to maintain their independence. Relatives interviewed felt staff treated the residents with respect.</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>	<p>FA</p>	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service.</p> <p>Staff receive education on cultural awareness during their induction to the service and as a regular in-service topic. Cultural awareness training was last held in December 2021. The caregivers interviewed were aware of the importance of whānau in Māori wellbeing. There was one resident who identified as Māori on the day of the audit. The registered nurses could describe identifying iwi, and preferences in the care plan. All staff interviewed stated they would feel comfortable asking the resident about any preferences they may have. The management team are currently reviewing their policy around Māori health and are working with the DHB and local Māori advisors to ensure their policies align and reflect the current Māori Health Action Plan 2020-2025.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p>	<p>FA</p>	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, family and/or their</p>

<p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>		<p>representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. All residents and relatives interviewed confirmed they were involved in developing the residents plan of care, which included the identification of individual values and beliefs. All care plans reviewed included the resident's social, spiritual, cultural, and recreational needs.</p> <p>The interview with the prospective owners who partly owned other care facility confirmed that they could describe communication with residents who have different cultures.</p>
<p>Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The organisation aims to create a workplace culture where all people are respected. Job descriptions include responsibilities of the position and signed copies of all employment documents are included in the five staff files sampled (two caregivers, one registered nurse, one quality lead and one DT). A staff Code of Conduct/house rules is discussed during the new employee's induction to the service and is signed by the new employee. Staff comply with confidentiality and the code of conduct. The registered nurses and allied health professionals' practice within their scope of practice. Interviews with the managers, registered nurses, activities team, kitchen staff and caregivers confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>The service meets the individualised needs of residents who have been assessed as requiring rest home or dementia level care. The quality programme has been designed to monitor contractual and standards compliance and the quality of service delivery in the facility. The service monitors its performance through quarterly resident/relatives' meetings, quarterly quality/management meetings (which include infection control, health, and safety), staff appraisals, satisfaction audits, education and competencies, complaints, and incident management. Staff meetings are held after the resident and quality/management meeting. Staff stated they are made aware of new/reviewed policies and sign to say they have read them. An environment of open discussion is promoted.</p> <p>Staffing policies include pre-employment and the requirement to attend</p>

		<p>orientation and ongoing in-service training. Caregivers' complete competencies relevant to their practice. The registered nurses have access to external training. Training has been provided to staff around caring for residents with dementia. The aim is to maintain a restraint free environment.</p> <p>The service continues to review their policies and embed good evidence-based practice, obsolete documents are removed. Infection control policies reviewed include Covid-19 prevention strategies and specific guidelines under each alert level in relation to preparing, responding to, and reviewing an outbreak of Covid-19. Pressure injury prevention is a quality focus for 2021 and supported through ongoing education for staff. Falls prevention strategies are steered by the falls prevention focus group that meets three monthly to implement efforts based on individual strategies.</p> <p>Residents and relatives interviewed spoke positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Policies and procedures relating to accident/incidents, complaints, and open disclosure policy alert staff to their responsibility to notify family/next of kin of any accident/incident that occurs. There is a section in the resident file regarding the relative/EPOA wishes of when they would like to be notified. The residents and relatives interviewed stated they felt the management team were approachable and helpful if they have any queries. Management have an open-door policy. Resident meeting minutes evidenced residents use the opportunity to discuss what is going well and any concerns they have.</p> <p>The paper-based accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed (from October 2021), identified family are kept informed. Relatives interviewed stated that they are kept well informed when their family member's health status changes. The relatives interviewed were appreciative of the regular phone calls from the manager during the lockdown period keeping them updated of what was</p>

		<p>happening within the facility. Regular newsletters are sent to relatives and residents keeping them informed of Covid-19 prevention strategies specific to the facility.</p> <p>Non-subsidised residents are advised in writing of their eligibility and the process to become a subsidised resident should they wish to do so. The residents and relatives are informed prior to entry of the scope of services and any items they have to pay for that are not covered by the agreement.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</p> <p>Residents and relatives interviewed stated they receive newsletters from the facility related to Covid-19 prevention strategies including screening of visitors and visiting hours.</p>
<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>	<p>FA</p>	<p>Elsdon Enterprises (Ltd) are the proprietors of Ashlea Grove Rest Home in Milton and family owned. The organisation owns three other facilities in Otago and one facility in Canterbury. The owners/managers (husband/wife team) have managed the facility since 2015. The manager (wife) is responsible for the general day to day non-clinical running of the facility. The operation manager (husband) is responsible for health and safety, HR, and maintenance. He also has oversight of health and safety of the other Otago homes. They are supported by the clinical lead/RN who has been in the role since 2015, and a part-time registered nurse (RN) with experience in aged care. Both have a current annual practicing certificate.</p> <p>The service can provide care for up to 37 residents (20 rest home and 17 dementia level care). On the day of the audit there were 27 residents in total (11 rest home residents including one YPD; and 16 dementia level residents). All other residents were under the Aged Residential Care (ARC) contract.</p> <p>The facility has two shared rooms in the dementia unit one was occupied and shared, the other one had single occupancy on the day of the audit. There is a policy in place which provides the registered nurse with the process of assessing residents' compatibility for sharing a room. The</p>

	<p>'checklist for evaluating shared room placement' for staff to complete, is in line with standard E3.3 section b and c of the ARC agreement. There is a consent form specific to shared rooms to be signed by both relatives/EPOA.</p> <p>Ashlea Grove has a business plan for 2020-2021. This includes the mission statement that sets out the vision and values of the service and is included in the information booklet. This is given to each resident and relative on admission. An organisational chart visually describes reporting relationships for the management structure. The owner/managers' report to the governing board monthly on a variety of topics relating to quality and risk management.</p> <p>The owners/managers have attended at least eight hours of training relating to managing a rest home including attendance at aged care provider meetings and inhouse management training.</p> <p>The current managers are also the prospective new owners of Ashlea Grove Rest Home. They partly own another three facilities in the region and another care facility in Christchurch. The intended change in proprietors from Elsdon Enterprises Ltd to Phantom 2021 Ltd is planned for 15 December 2021. Both of the prospective owners have experience in aged care management and working with residents with dementia. It is intended that one of the prospective owners will take over the full-time facility manager's role (non- clinical) at Ashley Grove Rest Home. The other owner will remain the operational manager of Ashley Grove and will continue to oversee the HR, maintenance and health and safety of the other three Otago facilities. A transition plan has been developed to ensure a smooth transition of finance and payroll services from Elsdon Enterprises Ltd to Phantom 2021 Ltd for Ashlea Grove Rest Home. Peer support from Elsdon Enterprises will continue. Both prospective owners interviewed are knowledgeable in the requirements to meet the Health and Disability Standards and obligations under the contract.</p> <p>The prospective owners stated that the quality management system, and policies and procedures will remain unchanged. There will be no proposed changes to the existing staff and rosters. There is an organisational chart with a reporting structure. Organisational reporting will include three monthly finance and risk reporting to advisors including accountant and solicitor. The clinical lead will maintain clinical oversight and will report to the facility manager. There is a business plan for 2021-</p>
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		2023 with a mission and philosophy statement and commitment to professional support, a stable workforce, robust quality management, business strengths, weaknesses, and opportunities.
<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	<p>During the temporary absence of the owner/managers, the care lead/RN will fill the role with support from the RN. Both owners and clinical lead live in close proximity from the facility.</p> <p>This on call arrangement will remain if there is a change in ownership.</p>
<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>	FA	<p>Ashlea Grove has fully implemented the quality and risk management programme. Internal audits occur as scheduled, collation of infections, incidents and accident data are all documented as taking place with corrective actions as needed. Meeting schedules include quarterly resident meetings, combined management/quality meetings (which includes members from all departments of the facility) followed by the staff meeting. Covid-19 prevention strategies including infection control and PPE, staffing, hygiene, security measures, the effect on residents with limiting visiting hours are discussed at meetings. Meeting schedules are maintained.</p> <p>There are procedures to guide staff in managing clinical and non-clinical emergencies. 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. A document control system is in place. Policies are regularly reviewed. New policies or changes to a policy are communicated to staff.</p> <p>Annual satisfaction survey results are collated and shared with staff. The 2021 survey shows overall improvement from 2020 with an increase of satisfied and very satisfied responses, particularly around safety and security. A separate food survey is completed in 2021 and a corrective action implemented to increase overall satisfaction with meals. The activities survey also showed an overall satisfaction rate of 88% for 2021. Corrective actions taken from comments from surveys have been implemented and were discussed at the management and staff meetings. Ongoing feedback from residents is gained at the resident meetings with</p>

		<p>corrective actions completed at the time.</p> <p>A health and safety system was in place with identified health and safety goals. Hazard identification forms and an up-to-date hazard register and hazard substance register is in place (last reviewed June 2021). There is a designated health and safety officer (operations manager), who is on site daily and has completed formal health and safety training. Health and safety issues are discussed at quality/staff meetings with action plans documented to address issues raised.</p> <p>The falls prevention group (resident, relative and management input) continues to focus on minimising the risk of each resident falling and enable efficient management of falls and residents who fall frequently. 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. An annual report was reviewed and discussed at the beginning of 2021. Meetings are three monthly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is collated/analysed for trends and discussed at meetings. Fifteen resident-related accident/incident forms were reviewed (ten dementia and five rest home). Each event involving a resident, reflected a clinical assessment and follow-up by a registered nurse. If an accident occurs afterhours, staff inform the on-call managers who contact the clinical lead if there are clinical concerns. Neurological observations are conducted for all unwitnessed falls. All incident reports reviewed evidenced RN follow-up and opportunities to prevent future incidents are documented (if any) on the incident report.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been no outbreaks since the previous audit or any section 31 notifications required to be completed.</p>
<p>Standard 1.2.7: Human Resource Management</p>	FA	<p>There are human resources management policies in place. The recruitment and staff selection process requires that relevant checks be</p>

<p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>completed to validate the individual's qualifications, experience, and veracity. Current practising certificates were sighted. Five staff files were reviewed (one registered nurse, two caregivers, one diversional therapist and one clinical lead) and there was evidence that reference checks and police vetting were completed before employment. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice and specific to their role. Annual staff appraisals were evident in all staff files reviewed for those who have been with the service over twelve months.</p> <p>The in-service education programme for 2020 has been completed and the plan for 2021 is being implemented.</p> <p>The registered nurses are able to attend external training, including sessions provided by the local DHB. Eight hours of staff development or in-service education has been provided annually. All staff have completed first aid training.</p> <p>There are 11 regular caregivers who work in the dementia unit. Six have completed the required dementia unit education modules. Four are in the process of completing the modules, these staff have been employed within the last 18 months. One newly employed caregiver has not yet commenced the dementia standards training. There is one caregiver who works in the rest home who has completed the dementia modules. Four caregivers across the rest of the facility have completed level 4 NZQA.</p> <p>The clinical lead/RN has maintained the interRAI competency.</p> <p>There are no immediate changes planned to existing staff numbers of allocated hours. The managers interviewed stated an understanding of skill mix required for the acuity of the residents and flexibility in the roster to extend hours to meet the needs of the residents.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The owner/managers are both on site 40 hours per week. The owner/managers are on-call after hours for any non-clinical issues and the clinical lead/RN on call for any clinical issues. The local general</p>

		<p>practitioner (GP) also provides after-hours care if required and caregivers have access to the local ambulance service. Interviews with caregivers, residents and relatives identified that staffing is adequate to meet the needs of residents. Advised that extra staff can be called on for increased resident requirements.</p> <p>There is an RN on site from 9 am to 5 pm during weekdays (clinical lead Monday, Thursday and Friday and the RN Tuesday and Wednesday).</p> <p>In the rest home (20 beds with 11 rest home residents including one YPD) there is one senior caregiver 7 am to 3 pm, one caregiver 8 am to 9 am. Afternoon shifts have one senior caregiver 3 pm to 11 pm and one caregiver 6 pm to 7 pm, and one senior caregiver on the night shift. The diversional therapist is scheduled between 1 pm to 2.40 pm.</p> <p>In the dementia care unit (17 dementia beds with 16 residents) there is one senior caregiver 7 am to 3 pm, and one caregiver 7 am to 1.30 pm. The afternoon shift has one senior caregiver 3 pm to 11 pm and one caregiver 4.30 pm to 8.30 pm and one senior caregiver on the night shift. The diversional therapist is scheduled between 2.40 pm to 5.15 pm.</p> <p>Short shifts can be extended when required. Staff and residents interviewed, confirmed that staffing levels are adequate, and that management are visible and able to be contacted at any time.</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 service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where unauthorised people cannot access them. Individual resident files demonstrated service integration. Entries are legible, dated and signed by the relevant staff member including designation.</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</p>	<p>FA</p>	<p>There are appropriate policies and procedures for entry to the service. This includes requirements and procedures to be followed when a resident is admitted to the service. The admission agreement reviewed aligned with the ARC contract and exclusions from the service were</p>

<p>services has been identified.</p>		<p>included in the admission agreement. Admission agreements were signed in the resident's records sampled. Residents and relatives reported that the admission agreements were discussed with them in detail by the owner/manager. All residents had the appropriate needs assessments prior to admission to the service. The service has specific information available for residents/families/EPOA at entry and it included associated information such as the Code, advocacy, complaints procedure and information about the dementia care unit.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There are documented policies and procedures to ensure exit, discharge of residents would occur in a safe and timely manner. Planned exits, discharges or transfers are coordinated with the resident and relatives to ensure continuity of care. Copies of documentation are saved in the resident's file.</p>
<p>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.</p>	<p>FA</p>	<p>There is an electronic medication management system in place. The registered nurses and caregivers responsible for the medication administration have current annual competencies and relevant education. Observation of the caregivers completing the lunchtime medication rounds showed they were fully compliant with medication administration policies and procedures.</p> <p>Medication policies align with accepted guidelines. Standing orders were in use, complied with regulations and had been reviewed by the GP. Self-administration policies and procedures were in place however there are no self-medicating residents. The temperatures of the areas where medications are stored is monitored daily and remains below 25 degrees Celsius. Medications requiring refrigeration are stored appropriately and the fridge temperature is monitored daily and is maintained between 2-8 degrees Celsius.</p> <p>Twelve medication charts were reviewed. All medication charts had photo identification and allergy status. All charts evidenced three monthly GP reviews. All medication charts have indications for use recorded for the PRN – 'as required' medications and staff record effectiveness of medication administered. The RN/clinical lead completes medication</p>

		reconciliation signing for medications from the pharmacy. Any errors made by the pharmacy are recorded and fed back to the pharmacy.
<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 food is prepared and cooked on site at Ashlea Grove. Two cooks cover the seven-day week roster with both having food safety training. The dietitian completed a review of the four-weekly summer/winter menu in July 2021. A current food control plan is in place expiring June 2022.</p> <p>Lunch is served in the two dining rooms by the cook and care staff. In the evening, carers serve the evening meal. Any resident preferences, allergies, dietary changes, and requirements are advised to the kitchen at admission and updated, as necessary. Meals were well-presented and residents stated there are alternative options available when requested.</p> <p>The dementia care unit has food available 24-hours per day. There are food supplements available for residents with weight loss, these include drinks as well as additives to food to increase caloric value. All residents are weighed monthly or more often as necessary.</p> <p>Fridge temperatures are recorded weekly and freezer temperatures are recorded monthly. Food temperatures had been taken and recorded daily. The area is clean and tidy and a current cleaning schedule is maintained. Dates when food is opened are recorded with expiry dates recorded on storage containers when food had been decanted from the original container. Residents interviewed were complimentary of the food and meals.</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>Declining entry records are kept. If a potential Ashlea Grove resident is declined entry it is usually because the care they require is not able to be provided or there are no beds available. When this occurs the Ashlea Grove clinical lead/registered nurse informs the referral agency and this is communicated to their family/whānau.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are</p>	FA	<p>The six files that were reviewed had appropriate Needs Assessment Coordination Service information prior to admission. Further to the</p>

gathered and recorded in a timely manner.		interRAI assessment there are clinical risk assessments that Ashlea Grove use at admission and six monthly; these include pain, skin integrity, continence and falls. The outcome of these were reflected in the long-term care plan. InterRAI assessments were completed for all files including the YPD resident, and it is evident that assessment forms part of the resident goals and objectives.
<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>The long-term care plans sampled were completed within three weeks of admission and were resident-focused and personalised. Resident files reviewed identified that resident/family/whānau were involved in developing the care plans and this was confirmed during interviews.</p> <p>Short-term care plans are used for short-term needs and changes in health status. Information about resident changes and care plan updates are given at handovers. Progress notes have both carers and clinical lead/RN records with a separate page for the GP.</p> <p>Behaviours that challenge have been identified through the assessment process. Twenty-four-hour multidisciplinary care plans describe the resident's usual signs of wellness, changes and triggers, interventions, and de-escalation techniques (including activities), for the management of challenging behaviours. Behavioural description records are used for residents that exhibit new or different from usual challenging behaviour in the long-term care plans. Established patterns of challenging behaviour are documented in the progress notes.</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>Care plans are current with interventions that reflect the clinical lead/RN assessments conducted and the identified requirements of the residents. Carers and clinical lead/RN confirmed there is adequate equipment available for wound care and continence (sighted). Continence products are available and there are assessments on file for urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Monitoring forms are utilised with residents who have identified needs in these areas, these include but are not limited to pain, food, fluid, restraint, vital signs, monthly weights. Established patterns of challenging behaviour are documented in the care</p>

		<p>plan with suggested ways of managing these.</p> <p>Referrals for specialist advice are available by (but not limited to) the nurse practitioner mental health, continence advisor, physiotherapist, and wound specialist.</p> <p>Wound assessment, management plans and written evaluations were completed and in place for two rest home and two dementia residents with wounds including one chronic leg ulcer, one skin tear, and six wounds acquired following surgical removal of lesion procedures.</p>
<p><b>Standard 1.3.7: Planned Activities</b></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>	<p>FA</p>	<p>Activities are planned over the week including weekends. On the days of the audit the activities programme began at 1.15 pm in the rest home and moved to the dementia unit at 2.40 pm. Activities are appropriate and meaningful to the residents in the areas.</p> <p>One diversional therapist (DT) work 21.25 hours per week, sharing time between the dementia care unit and the rest home. There is a further 30 minutes per day spent in the late afternoon in the dementia unit which caregivers provide activities including a late afternoon walk and activities for residents. There are also weekend activities planned for early afternoons. The programme is planned monthly in advance with the weekly plan displayed on noticeboards. Residents are asked for their preferred events at admission.</p> <p>There is a range of activities planned to include (but not limited to), craft, one-on-one, van outings, resident shop trolley, floor games and ball games as well as pet therapy. Visiting entertainers attend as Covid levels allow. The plan is determined by what is available (entertainers) and resident interests (information from their individual assessments). Residents were observed being encouraged to be part of the programme and participating in activities on the days of audit. All residents (rest home, YPD and dementia) are encouraged to maintain their community connections with activities for residents of both the rest home and dementia unit occurring outside Ashlea Grove.</p> <p>Daily attendance and evaluation of goals are recorded daily with a monthly summary. Resident meetings are held three monthly. Residents and relatives interviewed expressed satisfaction with the programme.</p>

		Residents in the dementia care unit have appropriate activities documented over the 24-hour period. There are two outside areas available for residents to use including a secure garden area. Residents interviewed indicated satisfaction with the activities on offer.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	In the files sampled, the long-term care plans were reviewed and evaluated six monthly or earlier as required in files sampled. InterRAI is the primary assessment tool with a range of other assessment tools used to inform the care plans. Residents and relatives who were interviewed reported they were involved in all aspects of care and reviews/evaluations of the care plans. In files sampled short term care plans (STCPs) were developed in response to acute events, these included (but are not limited to) wounds and urinary tract infections. GPs are called for acute health changes and all residents have a three-monthly medical review.  Relatives reported they are notified of incidents such as falls, GP visits and three-monthly reviews. The utilisation of the multi-disciplinary team (MDT) approach is demonstrated in the evaluation of care plans with feedback from GPs, the mental health nurse practitioner for services of older people, and other health professionals involved in the resident's care.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	There is evidence of documented policies and procedures in relation to exit, transfer or transition of residents. Referrals are made by the clinical lead/RN or GP to other specialist services. Residents and relatives are kept fully informed of the referrals.
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	The operations manager/prospective new owner also has the role of maintenance. There are documented processes for the management of waste and hazardous substances to ensure incidents are reported in a timely manner. Material safety data sheets were readily accessible for staff. There are adequate amounts of personal protective equipment in areas for use by staff.  Chemicals were stored safely throughout the facility. Chemical safety

		training has been completed by relevant staff.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. Handrails are installed in corridors, showers, and toilets to promote safe mobilisation. The physical environment minimises the risk of falls and promotes safe mobility by ensuring the flooring is appropriate and secure, bathroom floors are non-slip, and walking areas are not cluttered.</p> <p>There are two secure outside areas off the dementia care unit which have seating, paths, and shade available. There is a keypad lock system to entrance and exit doors in the dementia care unit. There are external gardens and seating and shade available for rest home residents. Interviews with residents and family members confirmed the environment was suitable and safe to meet their needs.</p> <p>Electrical safety test tag systems show this has occurred. Clinical equipment is tested and calibrated by an approved provider at least annually or when required. External contractors are used for maintenance as required, with regular maintenance completed by the operations manager. Maintenance records were reviewed and are clearly documented.</p> <p>Ashlea Grove has completed improvements/refurbishments to internal bathrooms and outside areas. The current building warrant of fitness expires on 12 July 2022.</p> <p>The hot water temperatures are monitored monthly and the records reviewed record temperatures between 42-45 degrees Celsius.</p> <p>The prospective owners do not have any further environmental changes planned.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with</p>	FA	<p>All toilets and shower doors have a vacant/occupied sign, so other potential users are aware the toilet is in use. There are toilets and showers in the rest home and dementia areas which have been refurbished and have new style locks as well as occupation signs to</p>

personal hygiene requirements.		ensure privacy.
<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	Resident rooms in both the rest home and dementia areas have been personalised and are spacious with adequate space for the safe manoeuvring of mobility equipment.
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The main lounge in the rest home is a combined dining room lounge and is used for routine activities as well as special events. Dining rooms and lounges are within easy walking distances to bedrooms. Residents interviewed confirmed they use their rooms or external areas if they want privacy or quiet time. There are adequate amounts of safe and comfortable seating provided.</p> <p>The dementia area has adequate safe access to all internal and external areas, including a garden area and separate decked area with seating and shade. The lounge and dining rooms have adequate amounts of safe and comfortable seating with a sensory room now in use.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Caregivers are responsible for laundry with a dedicated housekeeping role. Cleaning is done each day of the week and is signed off on a daily schedule. There is an ongoing focus on high touch areas. The cleaning chemicals are securely stored with safety material datasheets available for each product. The cleaner's trolley is stored in a locked room when not in use. Cleaning policies include decontamination of touch surfaces, reusable eyewear, and equipment between resident use.</p> <p>The laundry has a clean and dirty flow. It is evident that the laundry processes are implemented. Residents interviewed expressed satisfaction with the level of cleaning and quality of laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during</p>	FA	There is an emergency management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan. Fire evacuation drills are completed every six months, last

<p>emergency and security situations.</p>		<p>completed 12 August 2021. A contracted service provides checking of all facility equipment including fire equipment.</p> <p>Civil defence supplies are checked six-monthly. The facility has back-up lighting, power and sufficient food and personal supplies to provide for its maximum number of residents in the event of a power outage and portable gas heaters would provide alternative means of heating. Training in civil defence occurred in August 2021. There is sufficient water stored to ensure for three litres per day for three days per resident. There are alternative cooking facilities available with a gas barbeque. In the case of residents requiring to be evacuated, there is an agreement in place with sister facilities in Dunedin and a facility in Balclutha.</p> <p>Staff are responsible for checking the facility for security purposes on the afternoon and night shifts. Surveillance cameras are situated in three hallways and the kitchen.</p> <p>There are call bells in the residents' rooms and ensuites, communal toilets and lounge/dining room areas. Residents were observed to have their call bells in close proximity. There is at least one staff member on each shift with a current first aid certificate.</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>	<p>FA</p>	<p>The rest home and dementia care unit have adequate heating with wall hung radiators throughout. Individual rooms are heated with adjustable radiators. The owner (maintenance person) interviewed ensures the heating systems are running smoothly and that appropriate checks are performed. On the day of audit, the indoor temperature was comfortable. There are sufficient doors and external opening windows for ventilation. All bedrooms have good sized external opening windows which are designed and installed to promote ventilation and to be secured as needed. The residents and relatives interviewed confirmed the internal temperatures and ventilation are comfortable during the summer and winter months.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	<p>FA</p>	<p>The infection control coordinator (IC) is the registered nurse who has a defined job description that outlines the role and responsibilities. The infection control team which includes representatives from each area of</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>the service meet quarterly as part of the management/quality meeting. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management/quality team and through staff meetings. Meeting minutes are available to all staff and infection control is an agenda topic at staff meetings.</p> <p>There are adequate hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine. All staff have been vaccinated against Covid-19.</p> <p>New practices as advised by the DHB during the Covid-19 lockdowns were adhered to with records maintained. Procedures include adequate decontamination of touch surfaces and equipment (including slings) between use.</p> <p>Staff were observed to practice effective handwashing techniques.</p> <p>There is a register for each visitor to sign at the main entrance which declares wellness. Relatives confirm visiting to the facility is by appointment only. Appropriate signage is visible at the front entrance.</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>	<p>FA</p>	<p>There are adequate resources to implement the infection control programme at Ashlea Grove. The infection control nurse has maintained their practice by attending infection control updates and workshops through SDHB. The infection control team (the quality team) is representative of the facility. External resources and support are available when required. Infection prevention and control is part of staff orientation and ongoing training sessions. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</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</p>	<p>FA</p>	<p>The infection control manual outlines a range of policies, standards and guidelines and includes roles, responsibilities, procedures, the infection control team and training and education of staff. The policies are reviewed and updated as required, at least two yearly.</p> <p>A further Covid-19 information folder was developed as Covid-19 lockdown levels moved and as new information was published. Staff</p>

type of service provided.		interviewed all recounted new information being discussed at handovers, and the folder always on display for staff to peruse.
<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>All new staff receive infection control education at orientation, including hand washing and shoulder tap spot checks of hand washing. Infection control education is included in the annual education planner. There is an infection control manual in the nurses' office for reference to infection control matters.</p> <p>Resident education occurs as part of care delivery.</p> <p>Education on infection control was held in January and August 2021 and include donning and doffing of PPE.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	FA	<p>Infection monitoring is the responsibility of the IC coordinator. All infections are entered onto a monthly log. There is an end of month analysis with any trends identified and corrective actions for all infections. There are monthly and annual comparison of infection events. Outcomes are discussed at the quality/management and staff meetings. The GPs also monitor and review the use of antibiotics.</p> <p>There have been no outbreaks since the previous audit.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The restraint policy includes the definitions of restraint and enablers, which is congruent with the definitions in NZS 8134.0. The policy includes comprehensive restraint procedures. There are clear guidelines in the policy to determine what a restraint is and what an enabler is. The restraint standards are being implemented and implementation of any restraint and enablers is reviewed through internal audits, management/quality, and staff meetings. Interviews with the staff confirmed their understanding of restraints and enablers.</p> <p>Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there were no residents with restraint and no residents using enablers. The restraint folder is in the nurses' office with the register,</p>

		resources, and documentation required.
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## Specific results for criterion where corrective actions are required

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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
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## Specific results for criterion where a continuous improvement has been recorded

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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
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End of the report.