Heritage Lifecare Limited - Te Wiremu House

Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health's website by clicking here.

The specifics of this audit included:

Legal entity:	Heritage Lifecare Limited
Premises audited:	Te Wiremu House
Services audited:	Hospital services - Psychogeriatric services; Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
Dates of audit:	Start date: 13 September 2017 End date: 14 September 2017

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: 77

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

Te Wiremu House provides rest home, hospital and dementia care for up to 94 residents. The service is now operated by Heritage Lifecare Limited (since April 2017) and managed by a facility manager and a clinical services manager. Residents and families spoke positively about the care provided.

This unannounced surveillance audit was conducted against the Health and Disability Service Standards and the service`s contract with the district health board. The audit process included review of policies and procedures, review of residents` and staff files, observations and interviews with residents, family members, management, staff and a general practitioner.

This audit has resulted in one continuous improvement in relation to quality and risk management. The two areas identified as requiring improvement at the previous audit have been fully addressed.

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.

Open communication between staff, residents and families is promoted and was confirmed to be effective. There is access to formal interpreting services if and when required.

The facility manager is responsible for the management of complaints. A complaints register is maintained and demonstrated that complaints have been resolved promptly and effectively.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		All standards applicable to this service fully attained with some standards exceeded.

Heritage Lifestyle Limited is the governing body and is responsible for the service provided at the facility. Business, quality and risk management plans are documented and include the scope, direction, objectives, values and mission statement of the organisation. Systems are in place for monitoring the services provided, including regular weekly and monthly reporting by the facility manager and service manager to the governing body. The facility is managed by an experienced and suitably qualified manager who is supported by the clinical services manager.

A quality and risk management system is in place which includes an annual internal audit schedule, monitoring of complaints and incidents, health and safety, infection control, restraint minimisation and resident and family satisfaction. Collection, collation and analysis of quality improvement data is occurring and is reported to the quality and staff meetings, with discussion of any trends and follow-up as necessary. Meeting minutes and graphs of clinical indicators are provided to the staff. Formal and informal feedback from residents and families is used to improve services. Actual and potential risks are identified and mitigated and the hazard register is updated.

A suite of Heritage Lifecare Limited policies and procedures are being reviewed and implemented which are current.

The human resources recruitment management policy, based on current good practice, guides the system for recruitment and appointment of staff. A comprehensive orientation and staff training programme ensures staff are competent to undertake their role. A systematic approach to identify, plan facilitate and record ongoing training supports service delivery, and includes regular individual performance review. Registered nurses are encouraged to undertake post graduate study relevant to their role.

Staffing levels and skill mix meet contractual requirements and the changing needs of residents. After hours cover is available.

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.		Some standards applicable to this service partially attained and of low risk.

The multidisciplinary team, including a registered nurse and general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents are reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are safely managed and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. Residents verified satisfaction with meals.

Safe and appropriate environment

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

The building warrant of fitness is current and expires 6 July 2018. The building warrant of fitness is displayed publicly at reception.

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.

The organisation has implemented policies and procedures that support the minimisation of restraint. There are three enablers in use at the time of the audit. Restraint is only used as a last resort. Staff receive training annually and a restraint register is maintained. Staff demonstrated a sound knowledge and understanding of enabler and restraint processes and that enablers are voluntary and requested by the resident.

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.

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

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	1	16	0	1	0	0	0
Criteria	1	40	0	1	0	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and procedure and associated forms are documented and meet the requirements of Right 10 of the Code. Information on the complaint process is provided to residents/family/whanau on admission and those interviewed understood how to do so. The service has not received any external complaints such as police, coroner`s cases or Health and Disability Commissioner complaints since the last audit. The complaints register was reviewed. There were three complaints documented in the register since the change-over on the 14 August 2017 to Heritage Lifecare Limited quality and risk systems. Two complaints are fully closed out, dated and signed off by the facility manager, and one complaint was currently being responded to. The register sighted records complaints by the month. Complaints are reported weekly to the operations manager and to the quality compliance manager. All information is collated and complaints are used for improvement of service provision.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The care staff under the governance of Heritage Lifecare Limited no longer are employed to undertake tasks that they have not been trained to do. The care staff only complete caregiving responsibilities according to their position descriptions sighted. In the event of a caregiver undertaking another role of choice, they are required to complete relevant training or competencies related to the position. This is current good practice and is reflective on the roster and in the training records reviewed. The area of improvement from the previous audit has been

		addressed.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Residents and family/whanau members stated there were kept well informed of any changes to their relative`s status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. Staff clearly understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. Staff interviewed understood how to access interpreter services. The facility manager had access to the court interpreters and chose to use this service when needed. Staff represent many different nationalities and are able to provide translation/interpreter services as and when needed.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	CI	The strategic and business plans are now documented on the template provided by Heritage Lifecare Limited and the goals are personalised for Te Wiremu House for 2017 - 2018. The business plan objectives cover operation objectives, continuous quality improvement, administration processes, capital expenditure and site specific objectives. Action plans are included for each individual objective. The facility manager reports weekly and monthly as per reports reviewed to the governing group who monitor performance across the organisation, including emerging risks or any issues arising. The transitional change over from the previous ownership to Heritage Lifecare Limited in April 2017 was embedded into the strategic plan developed by the facility and clinical managers. The service is managed by a facility manager who holds relevant qualifications and has been in the role for nine years. Responsibilities and accountabilities are defined in a job description and individual employment agreement. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements and maintains currency through ongoing business and management training and has an extensive commitment to community services. The experienced clinical service manager works collaboratively with and supports the facility manager. The service holds contracts with the DHB for rest home, hospital, respite care, chronic care, dementia and younger persons disabled (YPD). On the day of the audit there were (27) rest home level residents, (31) hospital residents including 1 long term chronic care resident, (19) dementia residents totalling 77 residents. Two residents (rest home level) are receiving respite care and there are two residents are under 65 years.
Standard 1.2.3: Quality And Risk Management Systems	FA	The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes the management of incidents and complaints, audit activities as reviewed and a regular patient satisfaction survey, monitoring of outcomes, and clinical incidents including infections.

The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.		Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the quality and staff meetings. Staff reported their involvement in quality and risk management activities through audit activities and registered nurses holding additional roles and responsibilities in the organisation. Quality indicator data is collated each month and reported to the quality and compliance manager. Analysis of the set clinical indicators and relevant corrective action plans are developed and implemented by the clinical services manager to address any shortfalls. Resident and family satisfaction surveys are completed annually. Policies and procedures reviewed cover all necessary aspects of the service and contractual requirements, including reference to the interRAI long term care facility (LTCF) assessment tool and process. Heritage Lifecare Limited is transitioning their policies and procedures for the service to utilise. All are reviewed, based on good practice and are current. The document control system, referencing of relevant sources, approval distribution is organised by the organisation quality management team. The facility manager and clinical services manager are responsible for the removal, replacement and obsolete documents. The facility manager described the processes for the identification, monitoring, review and reporting of any risks and development of mitigation strategies. The facility manager is familiar with the Health and Safety at Work Act (2015) and has implemented requirements.
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	Staff document adverse and near miss events on an incident form. A sample of incident forms received showed these were fully completed, incidents were investigated, action plans developed and actions follow-up in a timely manner. Adverse event data is collated, analysed and reported electronically in a new system introduced 08 July 2017. Monthly statistics and a narrative report are generated and any trends are identified and reported back to staff. The facility manager described essential notification reporting requirements, including pressure injuries. Previously a notification register was maintained by the facility manager and this was sighted for 2016 – 2017. Any correspondence was retained in the register. The process has changed and if a notification or Section 31 notification is required, this now is reported to the operations manager, but the notification is the responsibility of the organisation`s quality and compliance manager. The one Section 31 notification was recorded 06 August 2017 for a resident admitted with a grade 4 pressure injury.
Standard 1.2.7: Human Resource Management Human resource management processes	FA	Human resource management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation`s policies are being consistently implemented and records are maintained.

are conducted in accordance with good employment practice and meet the requirements of legislation.		Staff orientation includes all necessary components relevant to the role. Staff reported that the orientation process prepared them well for their role. Staff records reviewed show documentation of completed orientation and a performance review after a three month period. Continuing education is planned on an annual basis, including mandatory training requirements. Care staff have with completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the provider`s agreement with the DHB. A staff member is member is the internal assessor for the programme. Staff have all completed education for dementia care. There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the required training and completion of annual performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service delivery, 24 hours a day, seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place, with staff reporting that good access to advice is available if needed. Care staff reported there were adequate staff available to complete the work allocated to them. Residents and family interviewed supported this. Observations and review of the roster cycle confirmed adequate staff cover has been provided, with staff replaced in any unplanned absence. At least one staff member on duty has a current first aid certificate.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and identifies all aspects of medicine management in line with the Medicines Care Guide for Residential Aged Care. A safe system for medicine management (using an electronic system) was observed on the day of audit. The staff observed demonstrated good knowledge and had a clear understanding of their roles and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they manage. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The RN checks medications against the prescription. All medications sighted were within current use by dates. Clinical pharmacist input is provided weekly. Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly and six-monthly stock checks and accurate entries. The records of temperatures for the medicine fridge and the medication room reviewed were within the

		recommended range. Good prescribing practices noted include the prescriber's signature and date recorded on the commencement and discontinuation of medicines and all requirements for pro re nata (PRN) medicines met. The required three-monthly GP review was consistently recorded on the medicine chart by one of the 20 GPs supporting residents in the facility. There were no residents self-administering medications at the time of audit. Appropriate processes are in place to ensure this is managed in a safe manner. There is an implemented process for comprehensive analysis of any medication errors.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by a kitchen manager and kitchen team, and is in line with recognised nutritional guidelines for older people. The menu follows summer and winter patterns and has been reviewed by a qualified dietitian within the last two years. Recommendations made at that time have been implemented. All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal comply with current legislation and guidelines. The facility has recently submitted a food safety plan for approval to the district council. Food temperatures, including for high risk items, are monitored appropriately and recorded as part of the plan. The kitchen manager has undertaken a safe food handling qualification, with kitchen assistants completing relevant food handling training. A nutritional assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences, any special diets and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Residents in the secure unit have access to food and fluids to meet their nutritional needs at all times. Special equipment, to meet resident's nutritional needs, is available. Evidence of resident satisfaction with meals was verified by resident and family interviews, satisfaction surveys and resident meeting minutes. Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and	FA	Documentation, observations and interviews verified the provision of care provided to residents was consistent with their needs, goals and the plan of care. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed, verified that medical input is sought in a timely manner, that medical orders are followed, and care is excellent. Care staff confirmed that care was provided as outlined in the documentation. A range of equipment and resources was available, suited to the levels of care provided and in accordance with the residents' needs.

desired outcomes.		
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	The activities programme is provided by two trained diversional therapists holding the national Certificate in Diversional Therapy. A social assessment and history is undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. The resident's activity needs are evaluated three-monthly and as part of the formal six- monthly care plan review. Te Whare Tapa Wha model of care is embedded within the ordinary patterns of life within the facility and is reflected in individual and group activities and residents' goals with regular and meaningful events offered with residents from all three units regularly mixing and joining activities together. Community groups of all ages regularly visit the facility and residents are encouraged and remain interactive with whanau, events and activities in the community. There are specific activities provided that are specific and meaningful to residents under the age of 65. Residents and families/whānau are involved in evaluating and improving the programme through residents' meetings and satisfaction surveys. Residents interviewed confirmed they find the programme interactive. Activities for residents from the secure dementia unit are specific to the needs and abilities of the people living there. Activities are offered at times when residents are most physically active and/or restless. This includes singing, reminiscing and one to one activities.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Formal care plan evaluations, occur every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care. Examples of short term care plans being consistently reviewed and progress evaluated as clinically indicated were noted for infections and wounds. When necessary, and for unresolved problems, long term care plans are added to an updated. Residents and families/whānau interviewed provided examples of involvement in evaluation of progress and any resulting changes.
Standard 1.4.2: Facility	FA	The building warrant of fitness was sighted and the expiry date is 6 July 2018. This was displayed publicly at

Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.		reception.
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	Laundry is undertaken on site in a designated laundry. The laundry at the previous audit was currently being totally renovated. Building work has been completed and all consents were closed off appropriately. Laundry staff had a sound knowledge of the laundry processes, dirty/clean flow and handling of any soiled linen. The laundry is well managed and clothes are returned to residents in a timely manner. Staff are trained in chemical management and chemicals are stored safely in a locked cupboard and were in appropriately labelled containers. The laundry has two new washing machines and two clothes driers and walls were soundproof and are easily cleaned to maintain infection prevention and control. The laundry is ventilated and an air conditioning unit has been installed. This was an area requiring improvement from the previous audit which has been addressed.
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	Surveillance is appropriate to that recommended for long term care facilities and includes infections of the urinary tract, soft tissue, fungal, eye, gastro-intestinal, the upper and lower respiratory tract. The IPC coordinator reviews all reported infections and these were documented. New infections and any required management plan are discussed at handover, to ensure early intervention occurs. Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff via regular staff meetings and at staff handovers. Graphs are produced that identify trends for the current year, and comparisons against previous years and this is reported to the quality manager. Data is benchmarked externally within the organisation. Benchmarking has provided assurance that infection rates in the facility are below average for the sector.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is	FA	Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. A restraint/enabler decision making process is available in the form of a flowchart to guide staff. Staff interviewed understand the difference between an enabler and a restraint and that an enabler is voluntary, used at the individual resident`s request and is the least restrictive.

actively minimised.		Restraint is used as a last resort when all alternatives have been explored. Currently three residents are using enablers/bedrails and 12 residents are using a restraint in the form of bedrails, pelvic belts or both. A restraint register is maintained by the clinical services manager who is the restraint coordinator for the service.

Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
Criterion 1.3.3.3 Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.	PA Low	All residents admitted to the facility had written initial assessments, short term and long-term care plans and evaluations provided with required timeframes. It was evident from staff interviewed that they knew the residents well. Family/whanau interviewed stated that they were happy with the care and communication provided. However, eleven (11) of seventy-seven (77) residents do not have an up to date interRAI assessment.	Not all residents had an up to date interRAI assessment	Ensure that all residents have an interRAI assessment to meet contractual requirements and time frames. 180 days

Specific results for criterion where a continuous improvement has been recorded

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
Criterion 1.2.1.1 The purpose, values, scope, direction, and goals of the organisation are clearly identified and regularly reviewed.	CI	The strategic and business plans were reviewed. Specific service goals were set for the coming twelve months inclusive of one goal to retain staff during the change over of ownership of the facility. The management addressed this positively by providing support and on-going professional development for staff and at the same time making the job fun and rewarding while providing all residents with a caring, professional and compliant service. Regular meetings were held with excellent attendance prior and during the transition of ownership to discuss any emerging issues. Meeting minutes were maintained and reviewed. The outcome of the meetings was that the staff were retained with ongoing management negotiations occurring with the new owner directors. This was emphasised by the management team as the approach required to ensure continuity of service provision. Staff were kept updated at all times by the facility manager and the clinical services manager of progress and expectations. Residents, family and the community at large were also well informed and participation was encouraged. The purpose, values and goals of the organisation were promoted throughout the initial transition of service providers and were continuously considered in all day to day activities provided by the service ensuring the best	A continuous improvement rating is made for achievement beyond the expected full attainment for the planning involved prior and during the transition of new ownership. This transition has been managed professionally, with management and staff working collaboratively together ensuring that the transition of service providers was managed efficiently, effectively and as smoothly as possible to ensure that the best outcomes for residents/families was

		outcomes for the residents and their families.	foremost achieved and for staff.

End of the report.