

Parata Anglican Charitable Trust Board - Parata Anglican Charitable Trust

Introduction

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

The audit has been conducted by Health and Disability Auditing New Zealand 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: Parata Anglican Charitable Trust Board

Premises audited: Parata Anglican Charitable Trust

Services audited: Rest home care (excluding dementia care)

Dates of audit: Start date: 27 July 2020 End date: 28 July 2020

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: 26



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

Parata Home provides rest home level of care for up to 26 residents. On the day of audit there were 26 residents.

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

An experienced manager (enrolled nurse) has been in the position for 27 years. She is supported by an assistant manager who is a registered nurse, a relief manager (enrolled nurse) and long-standing experienced staff. Residents and relatives commented very positively on the services and care received at Parata Home.

This audit identified shortfalls around the quality system, policies and Health & Safety documentation.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Parata 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 relatives to make a complaint is understood, respected and upheld by the service. Care plans accommodate the choices of residents and/or their relative/whānau. Complaints processes are implemented, and complaints and concerns are actively managed and well documented.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Parata Home has a documented quality and risk management programme. 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 a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff.

Human resources are managed in accordance with good employment practice. An orientation programme and regular staff education and training are in place. The 2020 education plan has been implemented. The manager is supported by an assistant manager and a relief manager who share on call when not on site. There are adequate numbers of staff on duty to ensure residents are safe. The residents' files are appropriate to the service type.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Residents are assessed prior to entry to the service and a baseline assessment is completed upon admission. The registered nurses are responsible for each stage of provision of care including assessments, care plans and evaluations. Risk assessment tools and monitoring forms are available and utilised. Residents and relatives interviewed confirmed they were very happy with communication and the care provided.

Activities include outings in the community and are planned and appropriate to the assessed needs and abilities of the residents who advised satisfaction with the activities programme.

The facility has a secure medication system. Staff responsible for the administration of medications complete annual competencies and ongoing education. The general practitioner reviews the medication charts three monthly.

The kitchen provides meals for the rest home as well as meals on wheels for the community. A new kitchen has been installed at Parata Home and it was opened on the day of the audit. The kitchen is well equipped for the size of the service. At admission residents' food preferences and dietary requirements are identified. Food, fluid and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs were being met.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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There are cleaning and laundry services with specific policies and procedures that are monitored through the internal auditing system. Chemicals are stored safely throughout the facility with material safety data sheets available. There are various styles and sizes of resident rooms with a mix of single and shared ensuite. The external and internal areas are accessible by wheelchair. There are pleasant garden areas that are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet and shower facilities are constructed for ease of cleaning. There is an emergency plan including fire safety and in the event of an emergency there is adequate civil defence equipment. The building has a current warrant of fitness.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation and safe practice policies and procedures are in place. Staff receives training in restraint minimisation and challenging behaviour management. On the day of audit, the service had one resident using restraint and no residents using enablers.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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The infection control coordinator (assistant manager/RN) is supported by the registered nurse. The infection control policy identifies the roles of the infection control coordinator. The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements. The staff at Parata Home remain proactive in the prevention of COVID 19, screening documentation remains in place on entry to the facility and staff remain vigilant of signs and symptoms of COVID 19. There have been no outbreaks since the previous audit.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	49	0	1	0	0	0
Criteria	0	98	0	3	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
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Parata Home ensures that all residents and relatives 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 is 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 staff (one manager, one assistant manager, one registered nurse, one enrolled nurse, two caregivers, one cook, one kitchenhand, one activities coordinator, one maintenance person and one lay chaplain-volunteer), 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 informed choices and give</p>	FA	<p>Six resident files were reviewed with all files having signed informed consent and admission agreements. Resident 'do not resuscitate' (DNR) forms were signed by competent residents with advance directives, if known, in the residents' files. Copies of enduring power of attorney (EPOA) for residents deemed incompetent to make decisions were also in the file. Processes are in place to ensure residents and where appropriate their relatives/whānau are updated with information about health and wellbeing to assist them in making appropriate information to make informed choices and decisions. The four residents interviewed confirmed carers ask for consent when undertaking cares.</p>

informed consent.		
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	Information on advocacy services through the HDC office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff received education and training on the role of advocacy services in March 2019.
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	Residents and relatives interviewed confirmed open visiting. Visitors were observed coming and going during the audit. The service encourages the residents to maintain relationships with their family, friends and community groups such as the RSA, and encourage their attendance at functions and events. The service ensures that the residents are able to participate in as much as they can safely and desire to do.
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	The complaints procedure is provided to residents and relatives on entry to the service. The manager maintains a record of all complaints, both verbal and written, by using a complaint register. The manager described documentation including follow-up letters and resolution, that if complaints were made, they would be managed in accordance with guidelines set by the Health and Disability Commissioner. Discussions with residents and relatives confirmed they were provided with information on complaints and complaints forms. Complaints forms are in a visible location at the entrance to the facility. There have been no complaints since the previous audit. Caregivers interviewed could describe processes around complaint management and described referring all residents and relatives wishing to make a complaint to the management team.
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their family. This information is also available in the foyer. The registered nurses discuss aspects of the Code with residents and their relatives on admission. All five residents and four relatives interviewed reported that the residents' rights are being upheld by the service. Staff received training on the code of rights in April 2019.
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	It was observed that residents are treated with dignity and respect. Residents and relatives interviewed were positive about the service in relation to their values and beliefs being considered and met. Privacy

<p>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>is ensured and independence is encouraged. Residents' files and care plans identified residents preferred names. Values and beliefs information is gathered on admission with family 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 on abuse and neglect along with the code of rights training session in April 2019.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Māori are valued and fostered within the service. The manager describes maintaining links with the Māori liaison. Staff receive education on cultural awareness during their induction to the service and as an annual in-service topic. The caregivers interviewed were aware of the importance of whānau in the delivery of care for Māori residents. There were no residents identifying as Māori on the day of the audit.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service identifies the residents' personal needs and values from the time of admission. This is achieved with the resident, relatives and/or their representative. Cultural values and beliefs are discussed and incorporated into the residents' care plans. The residents and relatives interviewed confirmed they were involved in developing the resident's 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. The lay chaplain interviewed was positive around the care of the residents and the care and attention to ensure all aspects of care are considered. The lay chaplain reported they are often invited sit with residents (following discussion with families) during palliative care.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>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. Professional boundaries are defined in job descriptions. Interviews with caregivers confirmed their understanding of professional boundaries, including the boundaries of the caregiver role and responsibilities. Professional boundaries are reconfirmed through education/training sessions and staff meetings.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of</p>	FA	<p>Each resident has their own general practitioner (GP). The GP for each resident, reviews residents identified as stable every three months, with more frequent visits for those residents whose condition is not deemed stable. There is a regular in-service education and training programme for staff. The service</p>

an appropriate standard.		has links with the local community and encourages residents to remain independent. The registered nurse is a Careerforce assessor who has supported caregivers to achieve qualifications.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<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.</p> <p>Incident reports are paper-based and have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed (from June 2020), identified family are kept informed. Relatives interviewed stated that they are kept informed when their family member's health status changes.</p> <p>An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated.</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 family 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>During the COVID 19 lockdown, the service quickly recognised the impact this would have on residents and implemented a communication strategy to ensure everyone had contact with their loved ones. The facility created a page on social media which provided the community with a link to the home. Staff assisted residents to use video calling and created chat rooms so a few members of the family could join the call, there were zoom meetings which religious services could be broadcast, and residents could attend. The facility utilised emails to update relatives of the pandemic and different policies as the lockdown restrictions eased. Relatives were asked for their input for ideas of entertaining the residents during the lockdown period. On average there were around 10 to 15 video chats per week on an appointment-based system so all residents had the opportunity to participate. As a result, relatives who do not live locally have requested this is an ongoing service to keep in touch more regularly with their loved ones, the relatives and staff overall feel this has reduced the impact of the lockdown period for the residents.</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</p>	FA	<p>Parata Anglican Charitable Trust board provides overarching governance to the service, with support provided by a board trustee/administrator. The service provides rest home level care for up to 26 residents. On the day of audit, there were 26 residents. All residents were under the Age-related residential care services agreement (ARCC).</p> <p>The facility is managed by a long-serving manager, who is an enrolled nurse. The assistant manager (registered nurse) and the relief manager (enrolled nurse) have both been in their positions for two years.</p>

<p>consumers.</p>		<p>The management team provide on call cover when not on site. The assistant manager/ RN is responsible for the clinical aspects of management, the EN(Manager) is responsible for the non-clinical aspects of management and has a current practicing certificate. The relief manager oversees health and safety, with support from the RN. A full-time administrator is employed to attend to facility business, human resource management and attend the board meetings. The manager provides a report to the board prior to board meetings. Two experienced registered nurses (including the assistant manager) provide clinical leadership and oversight. A philosophy, mission statement and key values are documented. The business/quality plan (2019-20) is reviewed three monthly by the management team.</p> <p>The manager has completed at least eight hours of professional development in the last year including attendance at the SDHB aged residential meetings and local meetings with providers via zoom. The assistant manager has attended external wound training days, infection control study days, completed syringe driver competency and completed the competency for COVID testing.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	<p>FA</p>	<p>During the temporary absence of the manager, the assistant manager (RN) provides oversight with support by the relief manager.</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>	<p>PA Low</p>	<p>Parata Home has a documented quality and risk management programme. The manager ensures internal audits, data collection, and collation of data are all documented as taking place with remedial actions as needed. Three monthly combined staff/quality meetings include infection control and health and safety.</p> <p>Quality improvement processes are in place to capture and manage non-compliances. They include internal audits, hazard management, risk management, incident and accident and infection control data collection and complaints management. A range of quality improvement data is discussed at three monthly combined quality/staff meetings. Meeting minutes reflect discussion of internal audits. Resident meetings have been held regularly.</p> <p>There are policies and procedures that are overall relevant to the service types offered and these have been signed as reviewed, however not all policies are in line with best practice and current legislation.</p>

		<p>Satisfaction surveys for 2019 could not be located, the service have started collating regular satisfaction surveys from individual residents prior to lockdown, a plan is in place to continue with the 2020 surveys. The three surveys completed and returned showed 100% satisfaction.</p> <p>A volunteer visits residents individually to gauge satisfaction or concerns with the service. It was identified in 2019 there was a poor turnout of residents attending the residents meeting. A volunteer visits the residents on a three-monthly basis and then collates a report of the level of satisfaction or dissatisfaction. Residents and relatives reported that the manager is very accessible and they feel comfortable discussing any issues that arise.</p> <p>There is a designated health and safety officer (enrolled nurse) with a caregiver assisting in this role at present. A risk management plan is in place. Health and safety issues are discussed at three-monthly quality/staff meetings with action plans documented to address issues raised. Hazards are identified, managed, and documented; however, the hazard register had not been reviewed. Falls prevention strategies are in place for individual residents.</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>Resident/ visitor Accident and Near Miss Reporting policy is in place to guide staff (link 1.2.3.3). Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Incident/accident data is collated and analysed for trends monthly. Fifteen resident related accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Neurological observations have been conducted for suspected head injuries and unwitnessed falls.</p> <p>The managers are aware of their requirement to notify relevant authorities in relation to essential notifications. There have been no notifications required to be sent since the previous audit, and there have been no outbreaks.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>There are human resources policies in place, including recruitment, selection, orientation and staff training and development (link 1.2.3.3). Six staff files reviewed (three caregivers, the relief manager, the registered nurse and one recently appointed kitchen assistant) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates is maintained.</p> <p>The service has an orientation programme in place that provides new staff with relevant information for safe work practice and includes buddying when first employed.</p> <p>A competency programme is in place. Core competencies are completed annually, and a record of completion is maintained (signed competency questionnaires sighted in reviewed files included: restraint,</p>

		<p>manual handling, hand hygiene, first aid and medication). A total of 20 staff have completed first aid training in July 2019.</p> <p>There is an annual education and training schedule being implemented. The service utilises an online system as part of the education programme, the registered nurse monitors progress and completion of online courses. The caregivers are encouraged to undertake NZQA training (Careerforce).</p> <p>Currently there are two cleaning staff who have completed level 2 NZQA, three caregivers have completed level 3 NZQA and one caregiver has completed and two currently completing level 4 NZQA. The registered nurse is the Careerforce assessor.</p> <p>Education and training for clinical staff is linked to external education provided by the district health board. RN specific training viewed included: syringe driver, wound care, and first aid. The two registered nurses are experienced and capable interRAI assessors.</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>There is a staffing rational and policy, staffing levels meet contractual requirements.</p> <p>The management team includes: the manager Monday to Friday, the assistant manager, the relief manager, and the registered nurse. After hours on call is provided by the management team.</p> <p>Staffing includes: the manager is on site Monday to Friday with a registered nurse on duty from 8 am to 4.30 pm Monday to Friday. There is always one manager on call after hours and at the weekends.</p> <p>Morning shift has four caregivers; 1x 7.15 am to 4.15 pm (senior medication competent), 1x 7.30 am to 4.30 pm, 1x 7 am to 10 am, 1x 7.30 am to 12.30 pm (1.30 pm at the weekend).</p> <p>Afternoon shift has three caregivers; 1x 2.30 pm to 11 pm (senior medication competent), 1x 4 pm to 11 pm, and 1x 6 pm to 9.30 pm.</p> <p>Night shift has one medication competent caregiver from 10.45 pm to 7.15 am.</p> <p>Interviews with the residents and relatives confirmed staffing overall was satisfactory.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential,</p>	<p>FA</p>	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. An initial support plan is also developed in this time. Personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Residents' files are protected from unauthorised access by being held securely. Archived records are secure in separate locked and secure areas.</p> <p>Residents' files demonstrated service integration. Entries were legible, timed, dated and signed by the</p>

and accessible when required.		relevant healthcare assistant or nurse, including designation.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is comprehensive admission information available to referrers, potential residents and their relatives. Resident agreements contain the information required by the Aged Residential Care Agreement. Family members and residents stated they received the information pack and have received sufficient information prior to and on entry to the service. Relatives reported that the manager and registered nurses are available to answer any questions regarding the admission process.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<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, relatives/whānau to ensure continuity of care. Copies of documentation are saved in the correspondence area of the resident's file.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>The system provides for safe medication management which meets current legislative requirements and safe practice guidelines, however, not all medication policies are in line with current medication guidelines (link 1.2.3.3).</p> <p>The medication system is paper-based and includes a blister pack system. Medicines arrive from the pharmacy; the packs are checked against the medication chart by whichever registered nurse is on shift.</p> <p>All medications are stored securely in accordance with requirements and checked by two staff. This is done by a registered or enrolled nurse, when one is available, and a medicines competent staff member. The medication room had adequate safe storage and was at the correct temperature – less than 25 degrees. The medication fridge temperatures are monitored weekly. There are no standing orders. Medications such as eye drops are dated on opening.</p> <p>The GP reviewed medications three monthly or sooner if required. Commencement and discontinuation of medications and reason(s) for 'as required' PRN medications were documented and meet requirements. There have been no medication errors but there is a system in place if required for analysis of these.</p> <p>There were three residents who self-medicate, all three have a competency signed by the general practitioner with appropriate checks done by the registered nurses.</p>

<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The kitchen had been upgraded and was operating for its first day on the day of the audit. All meals and baking are prepared and cooked on-site. There is a kitchen manager and a cook rostered to cover seven days of the week as well as a kitchenhand on each day. Staff have had appropriate food handling training. The refurbished kitchen is spacious and clean, and all the food was stored appropriately off the floor and dated correctly. Fridge, freezer and food temperature monitoring occurs as required by the Food Control plan. The food control plan is current and expires in March 2021.</p> <p>Residents have a nutritional assessment which contributes to the long-term care plan. Residents are encouraged to express their likes and dislikes and this information is provided to the kitchen. Residents' individual requirements are recorded and available on a noticeboard, the information is accessible to all staff. Special diets and individual requirements are catered for in the kitchen.</p> <p>The menu was last reviewed by the dietitian in 2019 and works over four, twelve-week rotations. Chemicals were appropriately labelled and stored with emergency management information available. Residents and relatives interviewed were complimentary around the meals and food provided.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>Any reasons for declining entry to the service are recorded by the service and communicated to the potential resident, relatives/whānau and the referral agency. Reasons for declining entry would be if the service was unable to provide the assessed level of care or no beds were available.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>The six files reviewed have the necessary information completed by the Needs Assessment Co-ordination Service prior to admission. InterRAI assessments were completed six monthly or when there was a change in the resident's condition in all files. The interRAI assessments are completed to identify current resident needs within the required timeframes. InterRAI assessments as well as a suite of clinical risk assessments which include (but are not limited to) pain, skin integrity, continence and falls are done at admission, six monthly or when there is a change in the resident's condition. The files that were reviewed demonstrated that the outcomes from assessments and risk assessments are reflected into care plans. The interRAI assessments are completed within the required timeframes. All staff interviewed were familiar with current resident needs.</p>

<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>All files reviewed had a summary care plan as well as personalised long-term care plans with interventions outlining the resident's needs. Long-term care plans sampled have been evaluated and updated within the required timeframes.</p> <p>Short-term care plans were in place and used when the residents' health status changes. Short-term care plans were reviewed regularly and are signed off as the goal is resolved or it becomes part of the long-term care plan. The care plans described goals, supports and interventions required to meet desired goals as identified during the ongoing assessment process. There is evidence of allied health care professionals involved in the care of the resident. Integration of records and monitoring documents are well managed. Relatives confirmed during interview they are involved in the care planning and review process.</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>	<p>FA</p>	<p>The sample of care plans confirmed the residents' supports and needs are being met. The resident file included assessment, records progress and has wound management plans and evaluations. Care plans are developed and then updated by the RN in response to assessed needs or a change in a resident's health status/condition, a three-monthly review or in response to a change in health condition is completed by the GP. The RNs utilise a three-monthly review form to collect information appropriate to the GP review. RNs were able to describe how they access specialist support, this included (but was not limited to) palliative care and wound management. Monitoring forms are utilised with residents who have identified needs, these included (but are not limited to) pain, food, fluid, restraint, vital signs, monthly weighs.</p> <p>Wound assessment, management and evaluation forms are in each residents file. There were five residents with eight wounds: one venous ulcer, one friction/pressure injury both on the same leg, two stage one pressure injuries, a burst boil, one tophi friction, two skin tears on the same resident. The district health board wound specialist has provided input into pressure relieving devices and wound management for the grade II injuries and is available as required to review any injuries and provide education. There are adequate supplies available for wound care and continence management. There is specialist continence advice as required.</p> <p>Residents and relatives/whānau interviewed were very satisfied their needs are being well met.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>There are two permanent part time employed activities staff working in total 36.5 hours. One is an enrolled nurse with 40 plus years' experience and the other has been taking a yoga programme at the day centre. Both have come into their roles in recent months, although they have collectively worked in</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>the service for thirty plus years. Each staff member has a current first aid certificate. The activity programme is delivered on a Monday and Tuesday by volunteers. On Wednesdays, Thursdays and Fridays each week, the programme is delivered in the in the community room with guests from the community, which provides a larger group for the residents to be involved with, which they enjoy.</p> <p>Activities care plans and evaluations were in all the files sampled. Care plans sampled were developed at admission and evaluated six monthly, within the timeframes required. Resident input into the activities programme was gathered at admission and from input at residents' meetings as well as any suggestions made by residents or relatives/whānau.</p> <p>There is a monthly planner that provides information regarding available activities which include (but are not limited to) movement to entertainers, yoga, themed craft activities, newspaper reading which provides opportunity for reminisce. The programme is flexible to allow for spontaneous events of interest occur.</p> <p>There is a large bus for taking residents out, usually weekly. Residents are encouraged to maintain previous interests and community links. If they are no longer able to independently do this the staff will work hard to assist this to occur with examples given. The relatives and residents interviewed expressed satisfaction with the activities provided and the staff involved.</p> <p>During the lockdown period, the activities team were available for chats with residents, helped with morning teas and continued to provide activities for residents including a lot of exercises and group games while observing social distancing. The activities team assisted residents with walks outside when the restrictions lifted.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>All of the files sampled included a summary care plan as well as short-term and long-term care plans. These included evaluations completed at the appropriate timeframes. Short-term care plans were used in response to changes in health status and these were evaluated and resolved or added to the long-term care plan if the problem is ongoing. GP reviews are completed at least three monthly or earlier as required.</p> <p>The utilisation of a multi-disciplinary approach is demonstrated in the evaluation of care plans with feedback from GPs, nurse practitioner and other health professionals involved in the resident's care.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or</p>	<p>FA</p>	<p>In reviewing resident files there is evidence of referral and associated documentation to other health and disability services. Residents and/or their family/whānau are involved as appropriate when referral to another service occurs.</p>

<p>referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>		
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>There are documented processes for the management of waste and hazardous substances to ensure incidents are reported in a timely manner. Staff have adequate amounts of personal protective equipment - gloves, aprons, and goggles are available for staff use and relevant staff have completed chemical safety training. Chemicals were stored safely throughout the facility with material safety data sheets readily accessible for staff.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The full-time maintenance person is on-call outside of business hours. This role manages the pellet boiler and general maintenance requests as well as the pickup of clients for the day care centre and Meals on Wheels. The Board of Trustees undertakes a monthly audit of the building and develops an ongoing maintenance plan. There is a current building warrant of fitness which expires 14 June 2021.</p> <p>Hot water temperatures have been tested and recorded monthly with readings between 43-45 degrees Celsius. Tagging of equipment, checks and calibration of equipment are up to date. There are preferred contractors who are available 24/7.</p> <p>There is adequate equipment available for staff to provide for the resident's needs as confirmed by caregivers during interview. Chair scales are available and have been tested and tagged.</p> <p>The building is spacious, with corridors wide enough for residents/visitors to easily pass and safety rails which provide independence for residents with mobility aids. The external areas are well maintained with safe access to all communal areas and outdoor areas. There is outdoor seating and shade provided. All outdoor areas are well maintained.</p> <p>The bus which is used for resident outings has both a current warrant of fitness and registration.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with</p>	<p>FA</p>	<p>Visual inspection evidenced toilet and shower facilities of an appropriate design to meet the needs of residents. The fixtures, fittings, floors and wall surfaces are constructed from easily cleaned materials.</p> <p>There are various styles of resident rooms; all have either their own ensuite or a shared ensuite. There</p>

adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.		are adequate numbers of communal and visitors' toilets. All toilet/shower facilities have security/privacy locks in place.
Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.	FA	Resident rooms have been personalised and are warm and spacious with a view of the gardens. Staff interviewed reported there is more than adequate space to allow care to be provided and for the safe use and manoeuvring of mobility aids and use of equipment required to provide care to residents.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There are a number of communal areas throughout the facility including the dining room, lounge, conservatory, chapel and a spacious day centre where the residents' activities take place three days a week. The dining room is spacious, and residents can see their meals served at the kitchen servery.
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	Cleaning and laundry occurs each day of the week with a dedicated cleaner and caregivers completing the laundry service. There is a designated locked area for the cleaner's trolley when it is not in use. All linen and personal clothing is laundered on site. The laundry functions well with a dirty to clean flow. There are adequate policies and procedures for the safe and efficient use of cleaning and laundry services with an internal monitoring programme to monitor effectiveness. There is a sluice room with personal protective equipment readily available. Residents and relatives interviewed were happy with the laundry and cleaning services.
Standard 1.4.7: Essential, Emergency, And Security Systems	FA	A fire evacuation plan is in place that has been approved by the New Zealand Fire Service. Six monthly fire evacuation drills take place (last in 22 July 2020). There are emergency management plans in place to ensure health, civil defence and other emergencies are included. There are emergency folders with

<p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>specific information and civil defence supplies held in a central location. All supplies including food stores are checked regularly. There are adequate supplies in the event of a civil defence emergency including a water tank. Emergency management is included in staff orientation and ongoing as part of the education plan. A minimum of one person trained in first aid is always on duty. 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. The building is secure after hours.</p> <p>In the event of a power outage there are electric and gas cooking facilities with barbeques. In the event of an emergency there are adequate food and water supplies. The service has civil defence and emergency plans in place to guide staff in managing emergencies and disasters.</p> <p>Call bells are in residents' rooms, lounge areas and toilets/bathrooms. There are adequate numbers of communal/visitors' toilets with security/privacy locks in place. The facility is secured at night.</p> <p>The emergency plan was implemented during the floods in February 2019. A neighbouring facility was to be evacuated. Parata Home accommodated eight residents in the large activities centre. The management at Parata Home contacted staff and prepared for the extra staffing required prior to the guests arriving. The water in the system was boiled prior to use, and the council provided a supply of clean water. The emergency phone line was in place and used in case of a power outage. Parata Home was able to function fairly normally during the floods, continuing to provide meals on wheels service to members of the community not affected by the flooding.</p> <p>All staff were aware of the emergency procedures and a sense of camaraderie within the staff meant there was little disruption to the running of the home. The evacuated residents stayed for three days. The residents in the community and the village were updated regarding meals, drinking water and given practical advice so they could remain independent. There was a sense of adventure amongst the residents who the manager reported seemed fairly relaxed and joined in the with the activities and daily routines as much as possible.</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 building is heated by a pellet boiler which maintains all areas at a safe and comfortable temperature. All areas are well lit and have adequate ventilation. There are windows in all the bedrooms which allow for plenty of natural light.</p>
<p>Standard 3.1: Infection control</p>	<p>FA</p>	<p>The infection control coordinator (IC) is the assistant manager/RN, who has a defined job description that</p>

<p>management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>outlines the role and responsibilities. The infection control coordinator is supported by the other registered nurse. The IC programme which is part of the quality plan is appropriate for the size and complexity of the service. The programme is approved and reviewed annually by the IC nurse, management and through the quality/staff meetings. Meeting minutes are available to all staff.</p> <p>There are adequate hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine. All COVID 19 documentation has been maintained and there is a register for all visitors to sign declaring wellness at the entrance to the facility. An updated outbreak management policy has been reviewed.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The IC coordinator provides a report to the quality/staff meetings. The IC coordinator has completed external education through the SDHB, the online COVID testing competency, use of personal protective equipment (PPE) and trained staff in the precautions and use of PPE through the COVID period. During the lockdown period, staff records of temperature checks each shift were maintained, contact tracing, and a case log of residents with symptoms was maintained. There is a good supply of hand gel, eye protection, gowns, aprons, gloves and masks and knew where to access more stocks if required. More stocks were in storage outside of the building.</p> <p>The IC coordinator can access the DHB IC nurse specialist, Southern Laboratory microbiologist, GPs and public health advice when required. The IC coordinator receives emails containing up to date information from the local hospital and SDHB.</p> <p>Infection prevention and control is part of staff orientation and induction. 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</p>	FA	<p>There are infection control policies and procedures in place, however, not all infection control policies are in line with current practices and legislation (link 1.2.3.3). During the audit, staff were sighted to be practicing best practice infection control measures and could describe these during interviews.</p> <p>Up-to-date policies and procedures are in place for COVID 19 supplied by the Health Quality and Safety Commission NZ. These include palliative care and COVID, an outbreak plan, notifications, guidance for admissions, checklists and logs and short-term care plans. A folder is maintained with new information as it comes out this is discussed with staff at handovers.</p>

practical, safe, and appropriate/suitable for the type of service provided.		
<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 infection control practices. Infection control education is included in the annual education planner. Education on the use of PPE and COVID 19 pandemic planning was provided in May 2020. Topical education sessions at the time are provided such as measles and influenza. Resident education occurs as part of care delivery.</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 into the infection log. There is an end of month analysis with any trends identified and corrective actions for infection events. The report provided to the quality/staff meeting provides a three-month look-back period. Outcomes are discussed at the 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 and is discussed at the combined quality/staff meetings. The registered nurse is the restraint coordinator. Restraint training is planned for August 2020.</p> <p>Interviews with the staff confirmed their understanding of restraints and enablers. There was one resident using a bed rail as a restraint on the day of the audit, and no residents using enablers.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint,</p>	FA	<p>The restraint coordinator is the registered nurse. Assessment and approval process for restraint use includes the restraint coordinator, resident/or relative/whānau representative and the general practitioner. The process includes an assessment, consent, and three-monthly review through the quality meeting as well as ongoing individual review.</p>

and ongoing education on restraint use and this process is made known to service providers and others.		
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>The restraint file reviewed for the resident with restraint contained a restraint assessment which included the factors listed in 2.2.2.1 (a-h).</p> <p>The registered nurse completes restraint assessments in partnership/consultation with the resident, their relative and the general practitioner for all residents who are being considered for the use of restraint or enablers. Restraint assessments are based on information in the care plan, resident/relative/whānau discussions and on observations by the staff.</p>
<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	FA	<p>The restraint minimisation policy identifies that restraint is only put in place as a last resort, where it is clinically indicated, and approval processes are obtained/met. Restraint is discussed with the resident, relative/ EPOA and the GP by the restraint coordinator prior to application. The restraint coordinator described the assessment form/process completed for all restraints and enablers. The assessment form for the resident currently using a bed rails as restraint was fully completed and on file.</p> <p>The care plan reviewed of a resident requiring restraint, included specific interventions to manage the identified risks. Monitoring forms were fully completed as instructed by the care plan. Restraint use is reviewed through the monthly restraint register, three monthly GP reviews and is discussed at the combined quality/staff meeting.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	FA	<p>The service has documented evaluation of restraint every three months at the GP review. The resident currently using restraint had only been using the bedrails for a short time, so had not yet had a formal review. The restraint coordinator described the procedure of completing the evaluation with the resident, relatives/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every quarter by the restraint coordinator at quality/staff meetings. Evaluation timeframes are determined by policy and risk levels.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the</p>	FA	<p>The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed three-monthly or sooner if a need is identified. The restraint coordinator monitors restraint usage, relevant incidents/accidents and any adverse outcomes. These are reported at the combined</p>

monitoring and quality review of their use of restraint.		quality/staff meetings. More urgent matters are discussed at shift handovers.
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Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.3</p> <p>The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy.</p>	PA Low	<p>The facility policies have been reviewed annually by the manager but there is little documented evidence of updates and amendments to policies. Current clinical practices and procedures were observed during the audit. The manager interviewed reported the service has been looking at renewing their policies, however, the document review prior to the audit revealed not all policies were in line with current good practice and current legislation.</p>	<p>The following policies and procedures have not been updated and amended over the years to reflect current accepted good practice, guidelines and/or legislation. (i) Health and safety policies including incident reporting, and hazard reporting are not in line with Health and Safety at Work Act 2015; (ii) Clinical procedures including care planning, wound and pressure injury management, and falls prevention do not reflect current good practice; (iii); Medication policies are not in line with current medication guidelines; (iv) Infection control policies and procedures do not meet current good practice.</p>	<p>Ensure all policies and procedures are in line with current good practice and guidelines and meet the requirements of current legislation where required.</p> <p>180 days</p>

<p>Criterion 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	<p>PA Low</p>	<p>The satisfaction surveys completed in 2018 show a high level of satisfaction, however these could not be located for 2019. A plan was in place to continue with the 2020 surveys.</p>	<p>There were no resident or relative surveys completed in 2019.</p>	<p>Ensure a satisfaction survey is completed annually as per quality plan and results are communicated to the residents, relatives and staff.</p> <p>180 days</p>
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	<p>PA Low</p>	<p>There is a designated health and safety officer and one of the caregivers is currently assisting with the role. A risk management plan is in place, health and safety issues are discussed at the time and at the combined staff/quality meetings. Caregivers interviewed described hazard management and hazard identifications forms completed, however, the hazard register was not up to date.</p>	<p>The hazard register has not been reviewed since 2018.</p>	<p>Ensure the hazard register is updated and reflects new hazards.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.