Kyber Health Care Limited - Waikiwi Gardens Rest Home

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Kyber Health Care Limited
Premises audited:	Waikiwi Gardens Rest Home
Services audited:	Rest home care (excluding dementia care)
Dates of audit:	Start date: 9 December 2020 End date: 10 December 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: 38

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

Waikiwi Gardens provides rest home level care for up to 42 rest home level residents. On the day of the audit there were 38 residents. The residents and relatives interviewed spoke highly of the service and care at Waikiwi Gardens.

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

Waikiwi Gardens is privately owned by two owner/directors (husband and wife). They are supported by a manager, assistant manager, resident manager and staff manager, two full-time RNs and experienced staff.

The service is focused on improving resident outcomes.

This audit identified shortfalls around, consents, notification requirements, education records, medication documentation, emergency food supplies, and infection control.

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

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

Organisational management

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.

The service has a documented quality and risk management system. 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 management team are supported by registered nurses who are on site five days a week and share on call when not on site. There are adequate numbers of staff on duty to ensure residents are safe.

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.

Waikiwi Gardens provides a comprehensive admission package. Registered nurses are responsible for each stage of service provision. They undertake assessments and develop the care plan, documenting supports, needs, outcomes and goals with the resident and/or family/whānau input. The care plans sampled were reviewed at least six monthly and the resident files demonstrated service integration. Resident files included the general practitioner, specialist and allied health input.

The activity programme is provided Monday to Friday with one activity coordinator responsible for the planning, development and evaluation of the residents' activity programme. The programme includes entertainment, outings and a wide range of other activities to meet the individual recreational, physical, cultural and cognitive abilities and preferences of the residents. The activity care plans are reviewed at least six-monthly.

Annual education and competencies are completed for staff who administer medicines. The electronic medicine charts viewed were reviewed as required but at least three-monthly. Medication policies reflect legislative requirements and guidelines.

All meals and baking are done on site. Dietary and cultural requirements are identified at admission and as required, with residents able to make requests for individual food preferences. Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and residents who require additional requirements/modified needs were 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.		Some standards applicable to this service partially attained and of low risk.

The building holds a current warrant of fitness. A civil defence/emergency plan is in place. There is a staff member on duty at all times with a current first aid certificate. There are documented processes for the management of waste and hazardous substances in place. Incidents are reported in a timely manner. Chemicals are stored safely throughout the facility. There is safe access to all lounges and dining areas and to the well maintained and updated gardens with outdoor seating areas with umbrella shading. Resident bedrooms are personalised. There are adequate communal shower/toilet facilities with privacy locks. Documented policies and procedures for the cleaning and laundry services are implemented with appropriate monitoring systems in place to evaluate the effectiveness of these services.

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.

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

The infection control is led by a registered nurse. The infection control policy identifies the roles of the infection control (IC) nurse and supporting team. Staff are informed about IC practises through meetings, training and information posted up on staff noticeboards.
Surveillance data is undertaken. Infection incidents are collected and analysed for trends and the information used to identify opportunities for improvements.

Policies, procedures and the pandemic plan have been updated to include Covid-19. Adequate supplies of personal protective equipment was sighted. Education was provided around Covid-19 and donning and doffing of personal protective equipment. The corrective actions identified at the district health board (DHB) Covid audit have been addressed.

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	44	0	6	0	0	0
Criteria	0	94	0	6	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

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

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Health and Disability Commissioner's (HDC) Code of Health and Disability Consumers' Rights (the Code) brochures are accessible to residents and their relatives. Policy relating to the Code is implemented. Management (two directors, one manager, one resident manager and one staff manager) and clinical staff interviewed (four caregivers, two registered nurses (RN), and one activities coordinator) could describe how the Code is incorporated into their everyday delivery of care. Staff receive training about the Code during their induction to the service, which continues annually through the staff education and training programme.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	PA Low	Waikiwi Gardens have established informed consent policies/procedures and advanced directives. Signed admission agreements were obtained on admission for seven resident files reviewed, this included one resident on younger persons with disabilities contract. There is an informed consent policy with systems in place to ensure residents, and family/whānau (if the resident is not competent to sign) are provided with information to make informed choices and decisions. The six long term resident files had general consents including photographs, and social media, however there was no consent documented for the respite resident. Resuscitation and advance directive forms were signed by the resident if competent and do not resuscitation forms were signed in the presence of the general practitioner. If residents are deemed not competent then they

		will be resuscitated. At interview both caregivers and RNs demonstrated a thorough understanding of informed consent and the associated processes. Relatives and residents interviewed confirmed they have been made aware of and fully understand informed consent processes and that appropriate information had been provided. Caregivers were observed seeking consent when undertaking care.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	Information of services through the HDC office is included in the resident information pack that is provided to residents and their relatives on admission. Pamphlets on advocacy services are available. Interviews with the residents and relatives confirmed their understanding of the availability of advocacy (support) services. Staff receive education and training on the role of advocacy service (link 1.2.7.5).
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	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 by encouraging their attendance at functions and events. Current residents are involved with the Blind Foundation functions, attend counselling services appointments, social worker appointments, and participate in the local choir. The service provides assistance to ensure that the residents are able to participate in as much as they can safely and desire to do. Resident meetings are held three-monthly. Regular emails were provided to relatives during the Covid-19 lockdown period. Waikiwi Gardens provide a 'social seniors' group. This is where eight senior members in the community attend Waikiwi Gardens for two days a week, previously five pre- Covid-19. The social seniors join the residents during the day joining in with activities and lunch.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	Complaints forms are available at the entrance of the dining room. Information around the complaints process is provided on admission. A record of all complaints, both verbal and written is maintained by the facility manager on the complaints register. Two complaints received since the previous audit (one in 2019, and one in 2020) were reviewed. Documentation reflected evidence of responding to the complaints in a timely manner with appropriate follow-up actions taken. Caregivers interviewed confirmed that complaints and any required follow-up are discussed at staff meetings. Residents and relatives advised that they are aware of the complaints procedure and how to access forms. Residents and relatives interviewed stated they felt comfortable discussing any concerns with the registered nurses or the management team.

Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	Details relating to the Code are included in the resident information pack that is provided to new residents and their relatives. Resident code of rights, and the advocacy service information is available at a central point in the main corridor. The registered nurses discuss aspects of the Code with residents and their relatives on admission. Discussions relating to the Code are held during the resident meetings. All five residents and four relatives interviewed, reported that the residents' rights are being upheld by the service.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The caregivers interviewed reported that they knock on bedroom doors prior to entering rooms, ensure doors are shut when care is being given and do not hold personal discussions in public areas. This was observed to occur during the audit. Caregivers reported that they promote the residents' independence by encouraging them to be as active as possible. All the residents and relatives interviewed confirmed that residents' privacy is respected. Guidelines on abuse and neglect are documented in policy. Staff receive annual education and training on abuse and neglect, which begins during their induction to the service. Residents are encouraged to attend their own spiritual care in the community. There is at least one church service a week. Spiritual needs are individually identified as part of the initial assessment and care planning process.
Standard 1.1.4: Recognition Of Māori Values And Beliefs Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.	FA	The service has guidelines for the provision of culturally safe services for Māori residents. There is a Māori health plan. On the day of the audit there were no residents that identified as Māori. Discussions with staff confirmed that they are aware of the need to respond with appropriate cultural safety.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe	FA	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

services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.		identification of individual values and beliefs. The care plans reviewed included the resident's social, spiritual, cultural and recreational needs.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	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.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The service meets the individualised needs of residents who have been assessed as requiring rest home level care as identified through interviews with care staff and through an audit of resident files. The service has policies and procedures, equipment, and resources to support ongoing care of residents. The quality programme has been designed to monitor contractual and standards compliance and service delivery in the facility. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. Meetings are conducted to allow for timely discussion of service delivery and quality of service including health and safety. Residents interviewed spoke very positively about the care and support provided. Both family and residents interviewed stated that the managers were very visible and encouraged open discussion at all times. Staff interviewed had a sound understanding of principles of aged care and stated that they are supported by the management team. Caregivers complete competencies relevant to their practice. Physiotherapy services are provided as needed following a referral. There is a documented education plan (link 1.2.7.5). A podiatrist is on site every three to four weeks. The service has links with the local community and encourages residents to remain independent. A member of staff at the sister facility is a Careerforce assessor who has supported caregivers to achieve qualifications.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive	FA	Policies and procedures relating to accident/incidents, complaints and open disclosure policy alert staff to their responsibility to notify relatives/next of kin of any accident/incident that occurs. Accident/incident forms have a section to indicate if next of kin have been informed (or not) of an accident/incident. Fifteen accident/incident forms reviewed (from November 2020), identified relatives are kept informed. Relatives interviewed stated that they are kept informed when their family

to effective communication.		member's health status changes. The service uses social media as a method of communication for families to keep up with what's on at Waikiwi Gardens. On the day of the audit there was one Columbian resident and one Samoan resident with limited English. There were members of staff who could speak Spanish and Samoan to assist with communication. An interpreter policy and contact details of interpreters is available. Interpreter services are used where indicated. 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.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	Waikiwi Gardens rest home provides care for up to 42 rest home level residents. On the day of audit there were 38 residents, including three residents on a 'younger persons with disabilities' (YPD) contract and two residents on respite care. All other residents are under the age-related residential care (ARRC) agreement. There were six independent boarders living within the rest home who are independent and do not receive care services. The facility is managed by two owner/directors (husband and wife) who also own another facility. One is responsible for the operational/staff management and the other is responsible for the maintenance/property requirements. The owner/directors (both non-clinical) have owned the rest home since March 2017. They are supported by a manager (non-clinical) who has been in her role for a year. The manager has a background in retail management and management of staff. The assistant manager (non- clinical) is responsible for procurement and finances. A staff manager and resident manager have been recently employed. The staff manager is non-clinical and has a background in coordination for a health care provider, has relief manager experience and has caregiving experience. The staff managers responsibilities include (but not limited to), rostering, communications with staff and caregiver and non-clinical staff appraisals. The resident manager is non-clinical and has a background in office management. The resident manager's responsibilities include (but not limited to); non-clinical communications with relatives, management of comfort funds, focusing on resident welfare, and escorting residents to appointments. The management teamwork across both facilities. There are two full-time RNs and one part time RN who are responsible for overseeing the clinical service across both facilities. There is a rostered system that ensures that at least one registered nurse (RN) is at each facility Monday to Friday. The directors and the manager described a low turnover of staff, with some staff celebrating 30 years, and 25 years of service. A business plan is in place for 2020 which identifies the purpose, vision, direction, scope and goals for

		the service, these are discussed regularly and evaluated annually. The 2021 business plan was in draft form at the time of the audit. The management team have maintained at least eight hours of professional development in relation to management of a rest home. There was a previous dispensation sent to the DHB and MOH in 2018 for a resident with declining condition for hospital level care to reside in Waikiwi gardens. The NASC assessment completed at the time assessed the resident for rest home level care. The resident has since deteriorated in condition and is requiring hospital level care. The service is now applying for a dispensation to the MOH for the resident to be assessed at hospital level care and to reside at Waikiwi Gardens.
Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.	FA	The owner/directors reported that in the event of their temporary absence the manager fills their roles with support from the management team and RNs.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	Waikiwi Gardens has fully implemented the quality and risk management programme which has been purchased from an external consultant. Internal audits, data collection, collation is documented as taking place with corrective actions documented and signed off when completed and discussed at meetings. Combined health and safety/infection control/quality and staff meetings, management meetings (operational), as well as two weekly clinical meetings ensure that quality data is communicated, discussed and issues acted upon. The clinical meetings include a review of complex resident care. The resident and relative satisfaction survey is held annually. The survey had 16 respondents (up from 11 respondents in 2019). There was overall high satisfaction around cleaning, laundry, staff being polite and courteous, and being involved in decision making. Fourteen respondents were satisfied with activities. Results were similar to 2019 results. Corrective actions were implemented around meals and odours. Waikiwi Gardens have placed as a finalist for the ‘Best age care small facility’ each year since 2018. This is based on reviews on an electronic website. There are procedures to guide staff in managing clinical and non-clinical emergencies. Policies and

		procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards. A document control system is in place. Policies are regularly reviewed (handwritten log in the front of the policy folder). New policies or changes to policy are communicated to staff. A health and safety system is in place with identified health and safety goals. One director and the manager have completed external health and safety training. A new initiative planned for 2021 is to develop a health and safety committee representative of the facilities. The management and staff were knowledgeable around hazard management. The hazard register was last reviewed in September 2019. This is planned for December 2020.
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.	PA Low	Individual reports are completed for each incident/accident, with immediate action noted and any follow-up action(s) required. Fifteen resident related accident/incident forms were reviewed. Each event involving a resident reflected a clinical assessment and follow-up by a registered nurse. Incidents are analysed for trends. Neurological observations are conducted for unwitnessed falls and suspected head injuries. Opportunities to minimise future risks were identified where possible. The registered nurses have revised the format of the incident reports to include the Glasgow coma scale and observations were completed at the time of the incident. Discussions with the manager and directors identified they were not aware of some instances of notifiable events. There have been no outbreaks since the previous audit.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	PA Low	There are human resources policies in place, including recruitment, selection, orientation and staff training and development. Seven staff files reviewed (the cook, the activities coordinator, three caregivers, the staff manager and one registered nurse) evidenced implementation of the recruitment process, employment contracts, completed orientation and annual performance appraisals. A register of practising certificates was maintained. 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. There is a documented education plan in place, however the attendance at the sessions held have not been recorded. The infection control coordinator has not yet attended infection control training (link 3.2.1). 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, manual handling, hand hygiene, cultural safety and medication). Staff are encouraged to gain New Zealand Qualification Authority through Careerforce. A member of staff is a Careerforce

		assessor at the sister facility. Currently there are six caregivers with level 2 NZQA, five caregivers with level 3 NZQA, and four caregivers with level 4 NZQA. All three registered nurses are competent in interRAI. Education and training for clinical staff is linked to external education provided by the district health board. RN specific training viewed included: wound care and palliative care.
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 staffing rational and policy, staffing levels meet contractual requirements. The management team includes: the directors, the manager, the assistant manager (off site) Monday to Friday. The staff manager (Monday to Thursday) and resident manager (Tuesday to Thursday). The registered nurses share on call for the caregivers after hours. The management team are on call for non-clinical matters. Staffing includes: Registered nurses Monday to Friday from 8 am to 5 pm. There are two caregivers (one senior medication competent) from 6 am to 2 pm, and one from 7 am to 11 am. This shift is extended to 1 pm over the weekends. There are two caregivers (one senior medication competent) from 2 pm to 10 pm, and one caregiver from 4 pm to 7 pm. Two caregivers (one senior medication competent) are on duty overnight. All senior caregivers and registered nurses have current first aid certificates. Interviews with the residents and relatives confirmed staffing overall was satisfactory. The rosters sighted confirmed that staff are replaced on the roster.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	The resident files 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 care 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. Residents' files demonstrated service integration. Entries were legible, timed, dated and signed by the relevant caregiver or nurse, including designation.

Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.	FA	All enquiries are reviewed by the facility manager and the RNs to ensure Waikiwi Gardens is able to provide for the specific needs of the resident and the level of care required. Prior to entry all residents have undergone a needs assessment that identifies the resident's level of care. Pre-admission information packs include information on the services and are provided for resident and families. Admission agreements for long-term residents are consistent with contractual requirements. The Waikiwi Gardens admission agreement specifies all exclusions from the service.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a safe and timely manner. Residents and their families are involved for all exit, transfers or discharges to and from the service. Most transfers are done by senior caregivers, so the yellow envelope transfer system continues to ensure all relevant documentation is made available to the receiving provider.
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.	PA Low	There are policies and procedures in place for safe medicine management. In the sample of files, the electronic medication charts were reviewed three-monthly by the GP as required. Resident photos and documented allergies or 'no known allergies' were documented on all but one chart, there is one resident who refuses to have his photo taken to update the last photo taken. All staff who administer medications have completed a medication competency and evidence of medication training is on their personal file. Self-medicating residents' policy and procedures are in place, with no residents self-administering on the days of the audit. There are no standing orders used, medications such as eye drops are dated on opening. All 'as required' (PRN) medications had been administered as prescribed including reason for administration and efficacy documented. Medication is administered by caregivers, and RNs. Annual competencies and training are completed by staff. When interviewed RNs and caregivers understood their medication administration role. All medications are stored safely. The temperature in the treatment room is monitored daily and on the day of the audit was 26.7 degrees Celsius. There is a cooling system in the room to bring it down to less than 25 degrees which it was when it was checked at other times on the days of the audit. The medication fridge temperature is monitored weekly. Medications received (blister packs) are checked on delivery by two RNs. Fourteen medication charts were reviewed which met the requirements for prescribing. Administration records demonstrated that all medications, including non-packed are signed as administered. The internal auditing programme includes medication audits completed by RNs. Medication errors were documented on incident forms and investigated with competencies of staff being reviewed where appropriate.

		The PRN – 'as required' medications have documented reasons for administration. However, a number of the charts reviewed did not consistently have the outcomes of the PRN – 'as required' medications recorded, a further six charts were reviewed, and they did not have consistent recording of outcomes.
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	All meals at Waikiwi Gardens rest home are prepared and cooked on site by an experienced cook and relief cook. The four-weekly seasonal menu was reviewed in February 2019 and will be reviewed in early 2021. Food preferences are met, and staff can access the kitchen at any time to prepare a snack as necessary. The RNs provide the kitchen staff with a dietary profile of resident dietary requirements that includes likes or dislikes, and updates are provided as required. Special diets including modified foods are available as required. At the time of the audit only diabetic diets were required. Staff were observed assisting residents with their meals and drinks in the main dining room. The cook interviewed was knowledgeable around residents' preferences and requirements. A kitchen cleaning schedule was documented, and cleaning was of an acceptable standard. Chemicals are stored safely within the kitchen. Resident meetings along with direct input from residents, provide resident feedback on the food services. Residents and family members interviewed were satisfied with the food and confirmed alternative food choices were available. The Food Control Plan audit has been completed however there were still corrective actions to take so the certificate has not been received. Fridge, freezer and end-cooked temperatures are monitored weekly.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	Any reasons for declining entry to the service are recorded by the service and communicated to the potential resident, family/whānau and the referral agency. Reasons for declining entry would be if the service was unable to provide the assessed level of care or there are no beds available.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely	FA	The resident files sampled demonstrated comprehensive care plan interventions. Care plans evidenced service integration and input from allied health as required. Care needs were resident-centred and have measurable goals that reflect the needs of residents' needs. Care plans reflected recent changes to residents' health and reflect the degree of risk from the assessments completed. Input into care plans is evident from residents (as able) and family/whānau. Short-term care plans

manner.		were in use for changes in health status, these were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The interventions in the resident files sampled were resident-focused and individualised. Care plan interventions were comprehensive and demonstrated service integration and input from allied health. Files sampled included individualised preferences and evidenced resident (as appropriate) and family/whānau involvement in the care plan process. The goals of the care plan were resident-centred, and the evaluations reflected them. Short-term care plans were in use for changes in health status and were evaluated on a regular basis and signed off as resolved or transferred to the long-term care plan. Care plans reflected recent changes to residents' health and reflect the degree of risk from the assessments completed. Residents interviewed confirmed they were involved in the care planning process.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Resident files sampled had risk assessments and initial care plans completed on admission. The long-term care plan is completed after three weeks. Care plans and interRAI assessments are reviewed six monthly or sooner if there is a change in the residents' condition. Monitoring forms are in place for vital signs including weight, wounds, behaviour management, food and fluid balance charts and pain management. When a resident's condition alters, the RN initiates a review and if required a GP or nurse specialist consultation. Caregivers follow the care plans and report progress against the care plan each shift. The RNs reported having access to sufficient medical supplies including dressings and continence products. The resident files sampled included a continence assessment and plan. Specialist continence advice is available. There is evidence that family members were notified of any changes to their relative's health. Discussions with families were documented in the resident's progress notes. Adequate dressing supplies were sighted in the treatment room. There was a range of equipment readily available to minimise pressure injury. There is access to a wound nurse specialist at the DHB as required. Wound management policies and procedures are in place. Wound documentation is available and includes assessments, management plans, progress and evaluations. There were four wounds for four residents, these included: one chronic ulcer, one blister, and two abrasions.
Standard 1.3.7: Planned Activities	FA	The activities coordinator was appointed three months ago, she works 30 hours per week, Monday – Friday. She is enrolled but has not started the apprenticeship programme for diversional therapists.

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.		At present she does not have a current first aid certificate so has not taken the residents out on her own. The social history and activity assessment are completed on admission to the service with the resident/family/whānau input (as appropriate). All resident files reviewed (except the respite file) had a current individualised social history, and activities plan, which is reviewed six-monthly, with a weekly progress note. The young person with disabilities file demonstrated an individualised activity programme that she enjoyed. Waikiwi Gardens has a number of places for large and small activities to take place, this allows for both large and small group activities as well as one-on-one activities. Individual monitoring of attendances at activities occurs to assist in the programme review. As part of the review of the activities programme, the activities coordinator has done a short survey with the residents to determine what they wish to have in the programme. There are a number of residents with cognitive impairment and the activities coordinator intends to develop 24-hour activities plans for these residents. Residents are encouraged to maintain their previous social contacts. The programme is varied and interesting with board games, music therapy, bell ringing, quizzes, newspaper reading, bowls, exercises, crafts and happy hour. The current monthly activity plan meets the group and individual preferences of the resident group. On one day of the audit a childcare centre visited the residents, other community groups also visit including community choirs, music entertainers including a music therapist and weekly church services.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Initial care plans are evaluated by the registered nurses within three weeks of admission. The long-term care plan is completed within the required timeframes and reviewed at least six-monthly or earlier if there is a change in health status. Long-term care plans are evaluated and document progress toward the residents' identified goals. Where progress is different from expected, the RNs update the care plan. This update is either a long or a short-term care plan. Short-term care plans are used for infections, wounds such as skin tears, and any decline in health status and these are regularly evaluated. If a short-term care plan is developed, they are either resolved or transferred to long-term care plans. The GP does at least a three-monthly review or more often as required.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)	FA	There is evidence of referral and associated documentation to other health and disability services in the resident files that were reviewed. If the need for other non-urgent services is indicated or requested, the GP sends a referral to seek specialist service provider assistance. There are documented policies and procedures in relation to exit, transfer or transition of residents. The on-call

Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.		policy ensures there is a RN on call at all times. Acute/urgent referrals are attended to immediately, sending the resident by ambulance if the circumstances dictate. Residents/EPOAs were involved and informed of the referral and the associated processes.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are documented processes in place for the management of waste and hazardous substances. The maintenance person confirmed there is safe storage and use of chemicals. Chemicals are correctly labelled and securely stored with material safety datasheets available and accessible for staff. Cleaners keep chemicals with them at all times when in use. Sluice facilities are available for the disposal of waste. There is adequate protective clothing and equipment appropriate to the recognised risks associated with waste or hazardous substance being handled. On the days of the audit staff were using protective clothing and equipment.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	The building has a current warrant of fitness. There are documented processes for the management of waste and hazardous substances to ensure incidents are reported in a timely manner. Safety datasheets and product sheets are readily accessible for staff. Chemical bottles sighted have correct manufacturer labels with chemicals stored in a locked chemical cupboard. There are chemical spills kits located throughout the facility which are easily accessible. All hoists, medical equipment and weigh scales have been recently calibrated, tagged and tested. Essential contractors are available 24 hours. The RNs and caregivers interviewed stated there is sufficient equipment to safely deliver the cares as outlined in the resident care plans, including hoists and pressure injury prevention equipment. In the case of an emergency YPD residents would be able to egress the facility with assistance from staff. Waikiwi Gardens is doing work to improve considerable work to improve the overall facility, this includes a new boiler, redoing the last of the areas to be re-tiled and refurbishing the conservatory area and roof. There is a preventative maintenance schedule in place. Hot water temperatures are checked monthly. A new boiler has been installed which has meant hot water temperatures are now consistently within safe parameters in all areas. The outside areas are easy to get to with seating and shade available. A designated smoking area is provided. The facility has an upstairs level which provides accommodation for independent boarders on the day of the audit five of the seven rooms were occupied.

Standard 1.4.3: Toilet, Shower, And Bathing Facilities Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.	FA	The fixtures, fittings, floors and wall surfaces are constructed from materials that can be easily cleaned. There are adequate numbers of accessible showers, toilets and hand basins for residents. Bathrooms have appropriately secured and approved handrails, along with other equipment/accessories that are required to promote resident independence. Toilets and showers are of an appropriate design with adequate space for mobility aids. Four resident rooms have an ensuite, there are communal toilets and showers as well. All have locks and shower curtains to ensure privacy. Residents interviewed reported their privacy is respected at all times.
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	There are 36 single rooms and 3 double rooms. One double room was singly occupied, one was occupied by a couple and the other by two close friends. Consent forms for sharing rooms were in place. Privacy curtains were in place. Residents and families are encouraged to personalise their rooms and the bedrooms viewed were personalised. There is adequate space provided to allow the consumer and service provider to move safely around their personal space/bed area.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	There is a spacious lounge with a large conservatory/sunroom off it, there is also a large activities room and smaller spaces including a smoker's area. Seating and space in the main lounge are arranged to allow both individual and group activities to occur. All communal areas are easily accessible for residents or with staff assistance.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	There are dedicated cleaning and laundry staff. There are adequate policies and procedures for the safe and efficient use of laundry services. All linen and personal clothing is laundered on site. The laundry is well equipped and well ventilated with a designated dirty to clean flow. The laundry person is responsible for the management of the laundry, including the transportation, sorting, storage, laundering, and returning clean laundry to residents. Cleaning and laundry policies and procedures are available for staff. Cleaners undertake the cleaning requirements. The effectiveness of the cleaning and laundry services is audited via the internal audit programme. Chemicals are stored and labelled according to legislation and staff have had appropriate training. Cleaning products were

		sourced in line with the Covid-19 requirements, extra surface cleaning was implemented and has been continued.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	PA Low	Emergency management plans are in place to guide staff in managing emergencies and disasters. There is an emergency/disaster management manual available for staff, residents and visitors in the event of specific emergencies/disasters (including: fire, earthquakes, floods, storms, tsunami and gas leaks). The fire evacuation schedule is currently being reviewed by a contracted company as advised by the fire service. Emergency signage has been updated and replaced. The service is currently awaiting approval. Training on the revised plan will commence once approved. Fire evacuation drills are scheduled to be conducted six-monthly. The staged evacuations planned were postponed due to both Covid-19 lockdowns. A fire safety quiz was completed by all staff instead. There was a failure with the emergency system resulting in a real evacuation in October 2020. This has been signed off by the fire department as a fire drill. A section 31 notification was completed during the audit. External providers conduct system checks on alarms, sprinklers, and extinguishers. The service has a generator for emergency power. There is a civil defence kit available and first aid supplies. There is a staff member on duty across 24/7 with a current first aid certificate. There is alternative gas heating and cooking available (two BBQs). Extra blankets, torches and supplies are available. There is sufficient food in the kitchen to last for three days in an emergency, and there is an additional supply of dry and canned food stored in the garage which was found to be outdated. There were sufficient emergency supplies of stored water (3,000 litres) available. Call bells are evident in residents' rooms, lounge areas, and toilets/bathrooms. The facility is secured at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	Waikiwi Gardens residents have adequate natural light and safe ventilation. All bedrooms have windows, which allow for plenty of natural light. The boiler ensures the environment is maintained at a comfortable temperature within bedrooms and communal areas. There are sufficient doors and opening windows for ventilation.
Standard 3.1: Infection control	PA Low	There is an infection control responsibility policy that includes responsibilities for the infection control

management 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.		coordinator. The infection control (RN) has been in the role since February 2020 and has a signed job description outlining the responsibilities of the role. The infection control programme is linked into the quality management system. The facility meetings include a discussion of infection control matters; however, the documented infection control programme could not be located at the time of audit. There is no documented evidence of an annual review of the IC programme. Policies, procedures and the pandemic plan have been updated to include Covid-19. Visitors are asked not to visit if they are unwell. All visitors including contractors are required to declare their wellbeing (implemented during Covid-19) when signing in with the paper-based register. Covid-19 precaution notices, QR code and hand sanitisers are available at facility entrances. Influenza vaccines are offered to residents and staff. Hand sanitisers are available throughout the facility.
Standard 3.2: Implementing the infection control programme There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.	FA	The infection control coordinator has not yet attended external infection control education (link 1.2.7.5). The infection control coordinator has access to the infection control nurse specialist at the DHB, laboratory technician, GPs and the public health team. Staff were well versed on the requirements around Covid-19. Procedures were in place for staff coming to and leaving work. Temperature checks were performed for staff arriving to work and residents with cold symptoms. All uniforms continue to be laundered by the service. Emails of changes and updates were sent to staff and relatives and discussed with residents. A red zone was identified as a precaution in case of residents contracting Covid-19.
Standard 3.3: Policies and procedures Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.	FA	There are infection control policies and procedures appropriate for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been developed and reviewed by an external consultant and the content of policies reflected current good practice. Policies, procedures and the pandemic plan have been updated to include Covid-19. Staff interviewed could fluently describe the isolation policy and when this would be implemented.

Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.	FA	Infection prevention and control education is included in the staff orientation and is included in the infection control calendar. Resident education occurs as part of daily care as appropriate. Staff interviewed described education that has been provided this year around preparation for Covid-19, donning and doffing personal protective equipment, hand hygiene and standard precautions, however there is no log of attendance documented (link 1.2.7.5).
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	There is a policy describing surveillance methodology for monitoring of infections. Definitions of infections are in place appropriate to the complexity of service provided. The infection control officer collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection reports, and short-term care plans are completed for all infections. Infection control data is discussed at the staff meetings. Trends are identified, and preventative measures put in place. Internal audits for infection control are included in the annual audit schedule. There have been no outbreaks since the last audit.
Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.	FA	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, RN and facility meetings. Interviews with the staff confirmed their understanding of restraints and enablers. Enablers are assessed as required for maintaining safety and independence and are used voluntarily by the residents. On the day of audit, there was one resident using bedrails as a restraint. No residents were using enablers.
Standard 2.2.1: Restraint approval and processes Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this	FA	A registered nurse is the designated restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurse, resident/or representative and medical practitioner.

process is made known to service providers and others.		
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident/or representative and medical practitioner. The service completes assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff in partnership with the family/whānau.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation policy identifies that restraint is only put in place where it is clinically indicated and justified and approval processes. Monitoring forms included regular two hourly monitoring. The service has a restraint and enablers register, which was up to date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint evaluation is required to include the areas identified in 2.2.4.1 (a) – (k). Evaluations are to be completed by the restraint coordinator and the GP at least three monthly or earlier if required. The resident file identified a current evaluation. The six-monthly care plan review also includes a review of restraint use with the family.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	Restraint usage is monitored regularly by the restraint coordinator. Corrective actions are monitored. Restraint is discussed at the quality/staff and clinical meetings. Individual restraint use is monitored and recorded by staff two hourly as directed in the care plan.

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 1.1.10.4 The service is able to demonstrate that written consent is obtained where required.	PA Low	Consent forms were in place and signed by the resident or enduring power of attorney, consents sighted included general consents and social media. The file for the respite resident had no signed consent form.	There was no signed consent form on file for the resident who was on respite care.	Ensure all resident files have signed informed consent forms. 90 days
Criterion 1.2.4.2 The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where	PA Moderate	The manager and directors could describe some instances where notifications are required, including stage 3 pressure injuries. During the audit, following a review of their policy around notifications, it was identified there were two occasions where notifications were required and not sent. These were sent on the days of the audit.	There were no section 31 notifications made for a sudden death and an emergency system failure as per policy. This was addressed on the day of audit.	Ensure the management team are knowledgeable around notification requirements. 60 days

required.				
Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.	PA Low	Caregivers, registered nurses and the management team verified the education plan has been followed and planned education sessions have occurred from January to October 2020. Since October 2020, attendance records have been maintained, however there is no documented evidence of attendance from January to October. A new staff attendance folder was created during the audit.	(i). There was no documented evidence of staff attendance at the education sessions held from January to October 2020. (ii). The infection control coordinator has not yet completed external infection control training (IPC RN is enrolled in a course on 4 April 21).	(i). Ensure attendance lists are maintained to evidence attendance at education sessions. (ii). Ensure that the infection control nurse attends infection control training. 180 days
Criterion 1.3.12.6 Medicine management information is recorded to a level of detail, and communicated to consumers at a frequency and detail to comply with legislation and guidelines.	PA Low	There are policies in place around medication management. Medication was observed to be administered and signed for at the time of administration. The sample of medication charts was increased to 20 only looking at the efficacy documentation of 'as required' medications. 'As required' medications were administered as prescribed by the GP. Indications for use was documented, however, the outcomes of the 'as required medications' are required to be provided.	Sixteen of twenty medication files did not have the efficacy of the as required medication recorded.	Ensure the efficacy of the 'as required' medication is documented. 90 days
Criterion 1.4.7.1 Service providers receive appropriate information, training, and equipment to respond to identified emergency and security situations. This shall	PA Low	There was a good supply of canned foods, and dry foods stored for emergencies, which are turned over annually, however, not all supplies were within the best before dates. The fire evacuation schedule has been documented and was being reviewed at the time of audit.	(i). Dry emergency food supplies had expired (this was addressed at the audit). (ii). Training and trial evacuations for the revised fire evacuation procedure have yet to be implemented. Since the draft report, advised that this	(i). Ensure all emergency food supplies are turned over regularly to prevent best before dates expiring.

include fire safety and emergency procedures.			was completed 21 January 21).	(ii). Ensure trial evacuations for the updated fire evacuation plan are implemented 90 days
Criterion 1.4.7.3 Where required by legislation there is an approved evacuation plan.	PA Low	The fire evacuation schedule is currently being reviewed by a contracted company as advised by the fire service. Emergency signage has been updated and replaced. The service is currently awaiting approval.	The updated fire evacuation schedule has yet to be approved.	Ensure the updated fire evacuation scheme is approved 30 days
Criterion 3.1.3 The organisation has a clearly defined and documented infection control programme that is reviewed at least annually.	PA Low	The infection control coordinator collates and analyses infection data monthly, however there is no current programme in place.	The infection control plan/documented programme could not be located at the time of audit. There is no documented evidence the programme has been reviewed annually	Ensure there is a documented infection control programme in place that is reviewed annually. 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.

No data to display

End of the report.