

# Sylvia Park Rest Home Limited

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## 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:

<b>Legal entity:</b>	Sylvia Park Rest Home Limited
<b>Premises audited:</b>	Sylvia Park Rest Home & Hospital
<b>Services audited:</b>	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
<b>Dates of audit:</b>	Start date: 11 June 2015    End date: 12 June 2015
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	79

# Executive summary of the audit

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## Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

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

Sylvia Park rest home and hospital is privately owned and operated for 20 years. The service is certified to provide rest home and hospital level of care for up to 81 residents. On the day of the audit there were 79 residents.

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

The owner/facility manager is supported by a general manager with accounting and human resource management experience. The full-time clinical manager has been in the role one year and has 20 years gerontology experience.

The service has an established quality risk management system and policies and procedures to enable staff to deliver good care. Residents and family/whanau interviewed commented very positively on the standard of care and services provided at Sylvia Park.

This audit identified improvements required around signed job descriptions, essential notifications, medication standing orders and self-medication and evaluation of care plans.

## 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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Sylvia Park provides care in a way that focuses on the individual resident. Cultural and spiritual assessment is undertaken on admission and during the review processes. Policies are implemented to support individual rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Information about the Code and related services is readily available to residents and families/whanau. Care plans accommodate the choices of residents and/or their family. Complaints processes are implemented and managed as per Right 10 of the Code. Residents and family interviewed verified on-going involvement with community.

## 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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Sylvia Park has an implemented a quality and risk management system that supports the provision of clinical care. Quality data is collated for infections, accident/incidents, concerns and complaints, internal audits and surveys.

There are human resources policies including recruitment, job descriptions, selection, orientation and staff training and development. The service has an orientation programme that provides new staff with relevant information for safe work practice.

There is an education programme covering relevant aspects of care and external training is supported. The staffing policy aligns with contractual requirements and includes appropriate skill mixes to provide safe delivery of care.

## Continuum of service delivery

<p>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.</p>		<p>Some standards applicable to this service partially attained and of low risk.</p>
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There is an admission package. A registered nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans are developed and demonstrate service integration. Changes to health status and interventions required were updated on the care plans to reflect the residents' current health status. Resident files include notes by the GP and allied health professionals. Medication policies reflect legislative medicine requirements and guidelines. All staff responsible for administration of medication completes education and medicine competencies.

An activities programme is in place. The programme includes outings, entertainment and activities that meet the recreational preferences and abilities of the residents.

All food is prepared on-site. Residents' nutritional needs were identified and documented. Choices are made available. Meals were well presented and a dietitian has reviewed the menu plan. Nutritious snacks are available.

## 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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Sylvia Park rest home and hospital has a current building warrant of fitness. Reactive and preventative maintenance is carried out. Chemicals are stored securely and staff are provided with personal protective equipment. Hot water temperatures are monitored and recorded. Medical equipment and electrical appliances have been calibrated by an authorised technician. Residents' rooms are of sufficient space to allow services to be provided and for the safe use and manoeuvring of mobility aids. There are sufficient communal areas within the facility including lounge and dining areas, and small seating areas. There is a designated laundry and cleaner's room. The service has implemented policies and procedures for civil defence and other emergencies and six monthly fire drills are conducted. External garden areas are accessible with suitable pathways, seating and shade provided.

## 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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The service has policies and procedures to appropriately guide staff around the use of enablers or restraints. A registered nurse is the restraint coordinator. An approval group meets three monthly to review restraint usage. There were 15 residents using restraints and one resident using an enabler. Staff receive training in restraint and managing challenging behaviour as part of the education plan.

## Infection prevention and control

<p>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.</p>		<p>Standards applicable to this service fully attained.</p>
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The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The infection control co-ordinator is the registered nurse. The infection control co-ordinator has attended external training. Staff attend annual infection control education. There is a suite of infection control policies and guidelines that meet infection control standards.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	46	0	4	0	0	0
<b>Criteria</b>	0	95	0	6	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
<b>Standards</b>	0	0	0	0	0
<b>Criteria</b>	0	0	0	0	0

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Sylvia Park rest home and hospital has policies and procedures that align with the requirements of the Code of Health and Disability Services Consumer Rights (the Code). Two caregivers and two registered nurses (RN) interviewed were able to describe how they incorporate resident choice into their activities of daily living.</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 informed consent.</p>	FA	<p>The service is committed to meeting the requirements of the Code of Health and Disability Services Consumers Rights. There are signed general consents and signed transport consents on nine of nine files sampled (three rest home, six hospital). Advance directives and resuscitation plans are appropriately signed in the nine files reviewed.</p> <p>Discussions with two registered nurses and two caregivers confirmed that they were familiar with the requirements to obtain informed consent for personal care and entering rooms. The two registered nurses stated that staff are familiar with advanced directives and the fact that only the resident (deemed competent) could sign the advance directive. There were nine admission agreements sighted and all had been signed.</p>

<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Residents are provided with a copy of the Code of Health and Disability Services Consumer Rights and Advocacy pamphlet (English and Chinese) on admission. Interviews with residents and family confirmed they were aware of their right to access advocacy. Advocacy pamphlets are displayed in the main foyer.</p> <p>D4.1d; Discussions with residents confirm that the service provides opportunities for the family/EPOA to be involved in decisions.</p> <p>ARC D4.1e. The resident files include information on residents' family/whānau and chosen social networks.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>D3.1h: Interview with residents confirmed relatives and friends can visit at any time and are encouraged to be involved with the service and care. Residents are encouraged wherever possible to maintain former activities and interests in the community. They are supported to attend community events, churches and interest groups in the community.</p> <p>D3.1.e: Interview with residents confirms the staff help them access community groups.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>There is a complaints policy to guide practice which aligns with Right 10 of the Code. The general manager leads the investigation of concerns/complaints consulting with the nurse manager for any clinical concerns/complaints. Complaints forms are visible for relatives/residents in the main entrance. The service has responded appropriately to nine concerns/complaints to date including verbal concerns. All concerns/complaints have been managed promptly and to the satisfaction of the complainant. Residents and families interviewed were aware of the complaints process and state all staff and management are very approachable.</p> <p>D13.3h. A complaints procedure is provided to residents within the information pack at entry.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>There is a welcome pack that includes information about the Code and this is discussed during the admission process with the resident and family. The Code is also written in Chinese and available at the main entrance. Five residents (three rest home and two hospital) and eight family members (one rest home and seven hospital) confirmed on</p>

		<p>interview they received all the relevant information during admission.</p> <p>D6.2 and D16.1b.iii The information pack provided to residents on entry includes how to make a complaint, Code of Rights pamphlet, advocacy and Health &amp; Disability (H&amp;D) Commission.</p> <p>D16.1bii. The relative and residents are informed of the scope of services and any liability for payment for items not included in the scope. This is included in the service agreement.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>There are policies in place to guide practice in respect of independence, privacy and respect. Staff were observed to be respectful of residents' personal privacy by knocking on doors prior to entering resident rooms during the audit. Five residents interviewed confirmed staff respect their privacy, and support residents in making choice where able. Resident files are stored out of sight. Staff receive training around abuse and neglect (link 1.2.7.5)</p> <p>D3.1b, d, f, i: The service has a philosophy that promotes quality of life, involves residents in decisions about their care, respects their rights and maintains privacy and individuality. Resident preferences are identified during the admission and care planning process with family involvement. The service actively encourages residents to have choices and this includes voluntary participation in daily activities.</p> <p>D4.1a: Nine resident files reviewed identified that cultural and/or spiritual values and individual preferences are identified on admission and integrated with the residents' care plan. Interviews with residents confirm their values and beliefs are considered.</p> <p>D14.4: There are clear instructions provided to residents on entry regarding responsibilities of personal belonging in their admission agreement. Personal belongings are documented and included in resident files.</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>Sylvia Park has a Māori health plan that includes a description of how they will achieve the requirements set out in A3.1 (a) to (e). Currently there are no Māori residents.</p> <p>D20.1i: There is a cultural safety policy to guide practice including recognition of Māori values and beliefs and identify culturally safe</p>

		practices for Māori. Staff interviewed were able to describe how they ensure Māori values and beliefs are met including the importance of family/whānau involvement.
<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 resident and family are invited to be involved in care planning and any beliefs or values are further discussed and incorporated into the care plan. Six monthly reviews occur to assess if needs are being met. Discussion with family and residents confirm values and beliefs are considered. Residents are supported to attend church services of their choice.</p> <p>D3.1g: The service provides a culturally appropriate service by ensuring it understands each resident's preferences.</p> <p>D4.1c: Care plans reviewed included the residents' social, spiritual, cultural and recreational needs.</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>Job descriptions include responsibilities of each role within the organisation. Copies of all employment documents are included in staff files (link 1.2.7). Staff comply with confidentiality and the code of conduct. Qualified staff and allied health professionals practice within their scope of practice. Staff meetings include discussions on professional boundaries and concerns as they arise (minutes sighted). Interviews with the clinical nurse manager, RN and care staff confirmed an awareness of professional boundaries.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>Policies and procedures meet the health and disability safety sector standards and are readily accessible to staff. All newly appointed staff work alongside a more experienced staff member. Internal and external education occurs. Staff complete relevant workplace competencies. Facility meetings occur regularly (as sighted). Staff are kept informed on all facility and clinical matters. The RNs have journal club incorporated into their monthly meetings. The service has two internal assessors qualified to ARC A2.2: Services are provided at Sylvia Park that adhere to the health &amp; disability services standards. Discussions with residents and family were positive about the care they receive.</p>
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and</p>	FA	<p>There is a policy to guide staff on the process around open disclosure. Accident/incident forms have a section to indicate if family have been</p>

<p>provide an environment conducive to effective communication.</p>		<p>informed of an accident/incident. Twenty of 20 incident forms reviewed for February 2015 identifies family were notified following a resident incident/accident. The clinical manager confirmed family are kept informed. The relatives interviewed confirm they are notified of any incidents/accidents. The resident satisfaction survey in July 2014 identified an improvement around telephone communication for families. Wireless phones were implemented in each nurse's station for resident/relative use. The residents predominantly speak another language (Chinese and Mandarin). Families and staff provide translation as required. The service roster staff on each shift who can communicate with the residents in their language. Family and resident meetings are held regularly.</p> <p>D12.1: 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 Ministry of Health "Long-term Residential Care in a Rest Home or Hospital – what you need to know" is provided to residents on entry.</p> <p>D16.1b.ii: The residents and family are informed prior to entry of the scope of services and any items they have to pay that is not covered by the agreement.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Sylvia Park rest home and hospital provides care for up to 81 rest home level of care residents. There are 79 dual purpose beds and two rest home beds. On the day of audit there were 25 rest home residents and 54 hospital residents which included two residents under 65 years of age.</p> <p>Sylvia Parks' mission and philosophy underpins the business plan, quality goals and nursing objectives. The 2014 -2015 business plan identifies objectives, timeframe and responsibility. There is documented evidence regular reviews held at the three monthly management meeting. Business plan updates are discussed at the monthly staff meetings (minutes sighted). The service have implemented the following environmental, service and clinical improvements in 2014: a) purchase of 80 recliner comfort chairs, three hoists, 14 new hospital beds, 14 new mattresses, four more sensor mats, refurbishment of bedrooms and dining rooms including the replacement of carpets with vinyl. b) A registered nurse (RN) office has been constructed on the first floor. c) Computers and internet connections have been installed in the</p>

		<p>RN's and clinical manager offices. d) Library area and service implemented for the residents, e) provision of Chinese TV channel, f) re-build of gardens and re-paint of outdoor furniture, g) complete review of policies and procedures, h) re-introduction of aged care training with two trained assessors on-site and i) InterRAI training completed for six RN's.</p> <p>The service has a documented plan with aims and ambitions set for 2015 that include (but not limited to); a) on-going aged care training for caregivers, b) complete InterRAI training for all RNs, c) implementation of Medimap is to go "live" July 2015, d) staff to attend English study course to commence July 2015, e) installation of healthcare computer system, and f) the purchase of a generator.</p> <p>Sylvia Park is privately owned for 20 years. The owner/facility manager holds a bachelor of sciences. The general manager has been in the role for six years and has a paper in accounting and commerce. He is responsible for the daily operations of the service, accounts, human resource management, maintenance and health and safety.</p> <p>A full-time clinical manager/RN with over 20 year's gerontology experience has been in the role at Sylvia Park for a year. She oversees the clinical services, RN's and caregiving team.</p> <p>ARC, D17.3di, The owner, general manager and clinical manager have attended at least eight hours of education including provider meetings, conferences and staff management seminars.</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>The owner/facility manager and general manager provide cover for each other's absence. A senior RN provides cover for the clinical managers leave.</p> <p>D19.1a; A review of the documentation, policies and procedures and from discussion with staff, identified that the service has operational management strategies, quality assurance programme which includes culturally appropriate care, to minimise risk of unwanted events and enhance quality.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained</p>	<p>FA</p>	<p>Sylvia Park has implemented a quality and risk management system. There is a current quality and risk plan in place. There are policies and procedures implemented to provide assurance that the service is</p>

<p>quality and risk management system that reflects continuous quality improvement principles.</p>		<p>meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001.</p> <p>All policies have been reviewed in the last year. Policy manuals are available for all staff. RNs have online access to the reviewed policies. An amendment log is maintained in each manual. The content of policy and procedures are detailed to allow effective implementation by staff. Staff interviewed confirm they are made aware at staff meetings of new/reviewed policies.</p> <p>Quality data including accidents/incidents, infection control, concerns and complaints, internal audit and survey outcomes, quality goals and quality improvements are discussed at the facility meetings. Minutes are available to all staff. Staff interviewed are kept informed on facility and clinical matters. Quality data is discussed at the meetings.</p> <p>There is an internal audit schedule that includes environmental, support services and clinical audits. Corrective action sheets are raised for any audit result less than 100%. Corrective actions are discussed at the relevant facility meetings. Corrective actions have been implemented (including re-audits) and are signed off when completed.</p> <p>2014 resident survey results have been collated. There were positive comments on the services. Results were fed back to participants (link 1.1.9).</p> <p>D19.3: There is an implemented Health and Safety and risk management system in place including policies to guide practice. The health and safety representative (general manager) has completed stage one of the health and safety training. Combined health and safety and infection control committee meetings are held three monthly. There is a current hazard register. Staff complete hazard report forms for identified hazards. Hazards that cannot be eliminated have been added to the hazard register (sighted) under the relevant area of work.</p> <p>D19.2g: Fall prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case by case basis to minimise future falls. Analysis of falls includes time and location, fall prevention includes the use of sensor mats and hip protectors. The physiotherapist (interviewed) is involved in resident initial assessments on admission and on-going treatment. The physio is</p>
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		<p>notified of any resident falls and completes a post falls assessment. The service has a falls prevention group led by the falls coordinator. The group meet three monthly and analyse all falls data, trends, and corrective actions and make recommendations for falls prevention as identified.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></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>	PA Low	<p>Twenty eight accident/incident forms for the month of February 2015 were sampled. There has been RN notification and clinical assessment completed within a timely manner. Accidents/incidents were recorded in the resident progress notes. There is documented evidence the family/whānau had been notified of incidents/accidents.</p> <p>D19.3c: The service collects incident and accident data and reports aggregated figures to the health and safety committee meeting. Staff interviewed confirm incident and accident data are discussed at the staff meeting and information and graphs are made available.</p> <p>D19.3b: The service documents and analyses incidents/accidents, unplanned or untoward events and provides feedback to the service and staff so that improvements are made. Trending data is considered.</p> <p>Management were not fully aware of the requirements of all essential notifications to be made to the correct authority.</p>
<p><b>Standard 1.2.7: Human Resource Management</b></p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	PA Low	<p>There are human resources policies to support recruitment practices. Nine staff files sampled contained all relevant employment documentation however not all job descriptions were signed by the employee. Current practising certificates were sighted for the RNs and allied health professionals. The service has an orientation programme in place that provides new staff with relevant information for safe work practice. Staff interviewed believed new staff were adequately orientated to the service on employment.</p> <p>The 2014 education planner has been completed as per schedule. Treaty of Waitangi training has not been offered. Staff attendance has been low at compulsory education.</p> <p>The service has two on-site aged care assessors (clinical manager and an RN) with allocated hours to work with caregivers progressing through the aged care national standards. Clinical staff complete competencies</p>

		relevant to their role including medication competencies.
<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>	FA	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. There is a roster that provides sufficient and appropriate coverage for the effective delivery of care and support. There are two RN's on morning and afternoon shifts and one on night shift. The on-call requirement is shared between the management team.</p> <p>There are dedicated cleaning, laundry and food services staff. The caregivers, residents and family interviewed inform there is sufficient staff on duty at all times.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within required timeframes into the resident's individual record. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. Individual resident files demonstrate service integration including records from allied health professionals and specialists involved in the care of the resident.</p> <p>D7.1 Entries were legible, dated and signed by the relevant caregiver or registered nurse including designation. Policies contain service name.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>There is an admission policy and an admission procedure. The service has information available for potential residents. There is an admission pack which includes all relevant aspects of service and family/whānau are provided with associated information such as the Health and Disability Code of Rights and how to access advocacy. There is written information on the service philosophy and practices in the information pack. All potential admissions are screened to check they have a completed needs assessment and the service can provide the level of care. The clinical manager and two registered nurses stated that there is good liaison with the needs assessors, social worker, mental health team GP's and nurse practitioner.</p> <p>The admission agreement reviewed aligns with the ARC contract. The nine admission agreements sighted had all been signed within the required timeframe. Exclusions from the service are included in the</p>

		admission agreement.
<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 guidelines for death, discharge, transfer and follow up. When transferring all relevant information is documented and transferred with the resident - including a copy of the resident admission form, most recent GP consultation notes and medication information. Resident transfer information is communicated to the receiving health provider or service. There is documented evidence of family notification of appointments and transfers on the relative contact form.</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>	PA Low	<p>Registered nurses administer all medications. All staff administering medications have completed an annual medication competency and attend annual medication education. Additional medication competencies include annual syringe driver competency. The service currently uses a robotic roll system for medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. Standing orders are used; however, the format does not meet the required guidelines. The medication fridge temperature is checked nightly.</p> <p>Self-medication residents are deemed competent to do so by the GP and registered nurse and they sign a consent form for self-administration. Self-administered topical medications are not stored safely in the resident's room.</p> <p>The 18 medication charts sampled included photo ID and allergies. The charts were clear and prescribed correctly. The signing sheets corresponded to the medication chart. All medication charts sampled showed evidence of being reviewed by the GP three monthly.</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>	FA	<p>All food is cooked on site in the main kitchen. A 'dumb waiter' is used to transport food between the floor levels. The temperature of the food is checked before leaving the kitchen. There are food covers available. There are two cooks on duty daily and they are supported by a kitchen hand. All kitchen staff have completed the food safety and hygiene standards (sighted). There is a kitchen manual and a cleaning schedule. Personal protective equipment is worn as appropriate. There are seasonal menus on a two week cycle. The menu has been reviewed by the dietitian February 2015. The service is in the process</p>

		of changing to a four week cycle on the advice of the consulting dietitian. The cooks receive dietary information for new residents and are notified of any dietary changes, weight loss or other dietary requirements. Special diets and allergies are listed and known to the food services staff. There is English and a Chinese menu. Moulded meals are available. Fridge and freezer temperatures are recorded daily (sighted). All food in the chiller, fridges and freezers are dated. Stock is rotated by date. Fresh vegetables and meat are bought daily. The kitchen is well equipped, clean and tidy. Residents and family interviewed spoke positively about the food provided. Food satisfaction is discussed at resident's two monthly meetings.
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	The service advised that they would record the reason (no bed availability or unable to meet the acuity/level of care) for declining service entry if this occurred. Potential residents would be referred back to the referring agency if entry is declined.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	The service is currently introducing the InterRAI assessment tool with an aim for all residents to be on InterRAI assessments by July 2015. Risk assessments are completed on admission and the outcomes of these were reflected in the resident care plans sampled. All interventions identify the required support.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Care plans are person centred and comprehensive. Care plans are easily accessible for caregivers. There is evidence of service integration and input from allied staff. Residents (three rest home and two hospital) interviewed were satisfied with care delivery and support from staff. Residents and family interviewed stated that they were involved in the care planning and care plan evaluation process. There is documented evidence on the care plan and relative contact form of family involvement in the care plan process.  Short term care plans are in place for short term needs and changes in health.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to	FA	When a resident's health status changes the registered nurse will review the resident and if required refer to the GP, physiotherapist or dietitian for a consultation. There is documented evidence on the relative

<p>meet their assessed needs and desired outcomes.</p>		<p>contact form of family notification when a resident's health status changes. Family members interviewed stated that staff are approachable if they needed to discuss their relative's health at any time.</p> <p>Dressing supplies are available and were sighted in the treatment rooms and on the well-stocked dressing trolleys. Continence products are available and were sighted and it is recorded in the care plan which product is needed and when. There is a comprehensive wound assessment with on-going evaluation and photos. There is GP involvement in one minor surgical wound and wound nurse specialist involvement in a chronic ulcer. The chronic ulcer is linked to the long-term care plan.</p> <p>Monitoring forms are in use by the registered nurses. Forms sighted included monthly blood pressure and weights, pain monitoring, nutritional and food monitoring and behaviour monitoring.</p>
<p><b>Standard 1.3.7: Planned Activities</b></p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>There is a senior activities coordinator, who has 29 years activities experience and works 16.5 hours a week to oversee and coordinate the activity programme. There are seven activities assistants, who cover Monday to Saturday. One activities assistant is currently completing the diversional therapy course. The activity team hold weekly meetings to discuss the programme.</p> <p>The weekly activity programme is displayed on noticeboards. There is a range of activities to meet the recreational preferences and individual abilities including entertainment, craft, Tai Chi, DVD's, Chinese Opera, walks, memory games, mah-jong and chess. Group exercises are held in the lounges daily. The activities assistants have one on one time with residents who are unable or who choose not to participate in the programme. There are weekly van outings for a drive or a shopping trip.</p> <p>There are prayers, hymns and bible stories each evening for those residents who wish to participate. The Buddhist monks visit regularly.</p> <p>Special events such as birthdays, Chinese New Year, Lantern Festival and Mother's Day are celebrated by residents, families and staff. Photos of these celebrations are on the walls in the lounges.</p>

		<p>There is a large satellite dish on site and this enables the residents to watch Chinese TV channels.</p> <p>The activities team hold resident meetings two monthly. Minutes are recorded.</p> <p>The activities coordinator completes an activities assessment on admission. The individualised activities plan is part of the long-term care plan and is reviewed at the same time.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	PA Low	<p>There are short-term care plans (STCPs) to focus on acute and short term issues. STCPs reviewed have been evaluated to identify that goals are being met.</p> <p>Care plan evaluations are completed, however six long-term care plan evaluations (five hospital, one rest home) do not identify that goals are being met. Evaluations include evidence of registered nurse, allied health, activity assistant and family input.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Referral to other health and disability services is evident in the sample group of files. The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to podiatry, dietitian, mental health services and wound care specialist.</p> <p>Discussion with the clinical manager and registered nurses identified that the service has access to GP's, ambulance/emergency services, allied health, dietitian, wound specialists and social workers.</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>	FA	<p>There is a waste and hazardous substance safety policy. Management of waste and hazardous substances is covered during orientation of new staff and chemical safety education is completed annually. All cleaning chemicals are clearly labelled and stored in locked cupboards. Safety data sheets and product wall charts are available. Approved sharps containers are used. These are easily identifiable. Gloves, aprons and goggles are available for staff use and staff were observed wearing appropriate protective equipment when carrying out their duties.</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 building holds a current warrant of fitness. There are two lifts and stair access between the two floors. One lift can accommodate a bed/ambulance stretcher. Reactive and preventative maintenance occurs and there is a planned maintenance programme. There is a designated maintenance person (general manager). An external contractor checks medical equipment annually and hoists six monthly. Hot water temperatures are monitored and maintained between 43-45 degrees Celsius. There are contractors for essential services available 24/7. Electrical testing and tagging has been completed.</p> <p>The living areas are carpeted and vinyl surfaces exist in bathrooms/toilets, kitchens and corridors. The corridors are wide and there are handrails in all corridors which promotes safe mobility. Residents were observed moving freely around the areas with mobility aids where required. There are external areas and gardens which are easily accessible (including wheelchairs). There is outdoor furniture and seating and shaded areas.</p> <p>The staff interviewed stated that they have all the equipment referred to in care plans to provide care. They stated that the new equipment provided has improved greatly over the last year.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are only two bedrooms without ensuite. These two rest home rooms share a toilet and have a hand basin in their rooms. There are adequate numbers of communal toilets and showers. There is appropriate signage, easy clean flooring and fixtures and handrails appropriately placed. Privacy is maintained at all times (observed).</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>Bedrooms are single with the exception of one double room occupied by a couple. The rooms are spacious enough to easily manoeuvre transferring and mobility equipment to safely deliver care. Residents are encouraged to personalise their rooms if desired.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	<p>FA</p>	<p>There are lounges of varying sizes in each area. This enables residents to have quiet time or socialise in small groups. Each area has a dining room. All lounge/dining areas are accessible and accommodate the equipment required for residents. Residents are able to move freely and safely and furniture is arranged to facilitate this. There is adequate</p>

needs.		space to allow for individual and group activities to occur. There are tea/coffee making facilities for families/residents. There are fridges in each dining area where residents may store personal food.
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There is a cleaning policy and cleaning schedules in place. Personal protective equipment is available in sluice, treatment, cleaning and laundry rooms. The cleaning trolleys are stored safely when not in use. Safety data sheets are available for cleaning and laundry staff. Staff were observed to be wearing appropriate protective wear when carrying out their duties.</p> <p>There is a laundry policy. There is a defined clean/dirty area within the laundry. Laundry chemicals are stored in a locked cupboard. There were adequate linen supplies sighted. Laundry and cleaning staff have attended chemical safety training. Cleaning and laundry audits have been completed. Residents and staff expressed satisfaction with the cleaning and laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>The service has an approved evacuation plan dated 16 July 2009. Six monthly fire drills are held. Staff receive training in emergency management (link 1.2.7.5) there is at least one first aider on duty at all times. There is an emergency plan and disaster preparedness policies and procedures. There is adequate water store, food supply, gas bottles for cooking and civil defence equipment available in the event of an emergency. There is an eight hour battery back-up for lighting. The call bell system is available in all bedrooms, bathrooms and communal areas. Security measures were increased following a security incident to include locked gates after hours which open automatically when fire alarms are activated. CTV camera has been installed. Afterhours access is by door bell.</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>	FA	<p>All bedrooms and communal areas are well ventilated and light. The temperature of the facility is comfortable and heated with heat pumps. All bedrooms have external windows which allow adequate natural light into the rooms.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of</p>	FA	<p>The infection control coordinator is a registered nurse (job description sighted) who has been in the role since April 2015. There is an infection</p>

<p>infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>		<p>control committee that meets three monthly. Infection control matters and monthly data are discussed at the infection control and health and safety committee meetings. The infection control programme was reviewed September 2014.</p> <p>Visitors are asked not to visit if they have been unwell. Influenza vaccines are offered to residents and staff. There are hand sanitizers throughout the facility and adequate supplies of personal protective equipment.</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>Infection control is managed by the infection control coordinator and infection control committee. The infection control coordinator has attended external education in June 2015. There is access to an external infection control specialist, district health board (DHB) infection control nurse, public health, and GP and laboratory personnel. The service has an outbreak management kit that is readily available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff.</p>
<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>The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education occurs annually. All newly appointed staff receive infection control education on orientation.</p> <p>Resident education is expected to occur as part of providing daily cares and discussed at resident meetings as appropriate.</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</p>	FA	<p>There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information monthly. Surveillance data is used to determine infection control activities and education needs in the facility. Definitions of infections are</p>

infection control programme.		<p>in place appropriate to the complexity of service provided. Infection control data is reported at the committee meetings and staff meetings. Monthly comparison and trends for infection rates are analysed. Information and graphs are displayed for staff. Trends are identified and quality initiatives put in place such as providing hand hygiene facilities in all bedrooms. The GPs review antibiotic use at least three monthly with the medication review.</p> <p>Systems are in place are appropriate to the size and complexity of the facility.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>There is a documented definition of restraint and enablers which is congruent with the definition in NZS 8134.0. The service is committed to restraint minimisation and safe practice. This is evidenced in the restraint policy and interviews with clinical staff. Restraint minimisation is overseen by a restraint coordinator who is a RN. There were 15 restraints in use and one enabler. The use of enablers is voluntary and requested by the resident. A full enabler assessment is completed prior to implementing the enabler. There is evidence of the resident consenting to the enabler. In addition, there is evidence of monitoring and evaluation of the enabler in use.</p> <p>The policy includes restraint procedures. The policy identifies that restraint is used as a last resort. The clinical nurse manager is the restraint coordinator. Training in restraint and challenging behaviour is provided. Restraint/enablers are discussed at the clinical meetings.</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, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint coordinator (RN) has been in the role six months and has a current job description. There is an approval group (clinical manager and key nurse for the residents on restraint), that meet three monthly to review all restraints and enablers in use. Assessment and approval process for a restraint intervention included the restraint coordinator, registered nurse, resident/or representative and medical practitioner. The resident/relative receive written and verbal discussion on the restraint process.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These are undertaken by suitably qualified and skilled staff in partnership with the family/whānau.</p>

undertaken, where indicated, in relation to use of restraint.		The restraint coordinator, a registered nurse, the resident and/or their representative and a medical practitioner are involved in the assessment and consent process. A resident/family risk questionnaire is completed prior to a full assessment. In the four files with restraint reviewed assessments and consents were fully completed.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The restraint minimisation manual identified that restraint is only put in place where it was clinically indicated and justified and approval processes had been followed. There is an assessment form/process that was completed for all restraints and enabler that identified risk associated with the use with restraint/enabler. Restraint use and risks are documented in the resident care plan. Monitoring forms included frequency monitoring and cares provided during the episode of restraint. The service has a restraint and enablers register which is up to date.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint every six months or earlier as determined by risk levels. In the files reviewed, evaluations had been completed with the resident, family/whānau, restraint co-ordinator, key RN and medical practitioner. Restraint practices are reviewed at Approval group meeting and clinical meetings. The evaluations sighted in resident files have been completed with the resident, family/whānau, restraint co-ordinator and medical practitioner.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	The service actively reviews restraint as part of the internal audit and reporting cycle. Earlier reviews are completed sooner if a need is identified by the restraint co-ordinator. Any adverse outcomes are included in the restraint co-ordinators monthly report to the relevant group and meeting. Restraint use is discussed at staff meetings. All staff receive orientation to restraint and enabler use. There is annual education on challenging behaviours and restraint use. Staff complete a restraint competency.

## 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 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	Discussions with management confirms an awareness of the requirement to notify relevant authorities in relation to RN cover, outbreaks, loss of essential services, industrial action, missing resident and complaints involving the Health and Disability commissioner.	The service had not notified (Section 31) the relevant authority following an incident requiring police investigation.	<p>Ensure essential notifications are made as per the conditions of certification.</p> <p>30 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	All staff files contained job descriptions which were signed by the employer.	Four out of nine job descriptions had not been signed by the employee.	<p>Ensure all job descriptions are signed by the employee</p> <p>180 days</p>
Criterion 1.2.7.5	PA Low	The 2014 education planner has been	(i) Staff have not attended Treaty of	(i) Ensure all staff

<p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>		<p>completed. The 2015 education plan has commenced. Staff attendance lists and records are maintained. RN's have access to external education.</p>	<p>Waitangi cultural training in the last two years. (ii) Staff attendance at compulsory education is low. There is a total of 81 which includes 56 clinical staff. Examples of low attendance are sexuality and intimacy (15), privacy and dignity (20), emergency management (11), falls prevention (16) and hazard management (15).</p>	<p>attend Treaty of Waitangi cultural training. (ii) Ensure the service reviews how to increase staff attendance at education sessions.</p> <p>180 days</p>
<p>Criterion 1.3.12.1 A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>PA Low</p>	<p>The service currently uses a robotic roll system for medications. All medications are checked on delivery against the medication chart and any discrepancies are fed back to the supplying pharmacy. There is a Standing Order in place that has been reviewed annually by the GP and lists medications for use as indicated for RN administration only.</p>	<p>The standing orders do not document the contraindications for each medication listed as per the MOH Standing Order guidelines.</p>	<p>Ensure standing orders meet Ministry of Health guidelines.</p> <p>60 days</p>
<p>Criterion 1.3.12.5 The facilitation of safe self-administration of medicines by consumers where appropriate.</p>	<p>PA Low</p>	<p>Self-medicating residents are deemed competent to do so by the GP and the registered nurse. They sign a consent form for self-administration</p>	<p>Self-administered topical medications are not stored in a locked area in the resident's room.</p>	<p>Ensure all self-administered topical medications are stored in a locked area in the resident's room</p> <p>30 days</p>
<p>Criterion 1.3.8.2 Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired</p>	<p>PA Low</p>	<p>Short-term care plans are documented and evaluations indicate the response to the intervention or progress towards the goals. Three of nine long-term care plans have been evaluated and identify if the residents goals have been met or unmet.</p>	<p>Six out of nine long-term care plans (five hospital, one rest home) have been evaluated, but evaluations do not identify if the residents goals are being met or unmet.</p>	<p>Ensure evaluations are documented six monthly or as required and identify progress to meeting goals</p> <p>90 days</p>

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

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

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

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

No data to display
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End of the report.