

# Oceania Care Company Limited - Palmerston Manor 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 Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Palmerston Manor Rest Home

**Services audited:** Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)

**Dates of audit:** Start date: 9 August 2016 End date: 10 August 2016

**Proposed changes to current services (if any):** The service has applied to remove disability services to their certification.

**Total beds occupied across all premises included in the audit on the first day of the audit:** 48

# 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

Palmerston Manor can provide rest home and hospital level care for up to 48 residents. The service has applied to remove disability services from their certification. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the District Health Board. The audit process included the review of policies, procedures, supporting documents, resident files, staff files and observations, interviews with residents, family, management and staff.

Improvements are required in the following areas; meeting minute records, wound care assessments and medicines management.

## 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.
--	--	--

Staff are able to demonstrate an understanding of residents' rights. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect and receive services in a manner that considers their dignity, privacy and independence. Information regarding resident rights, access to advocacy services and how to lodge a complaint is available to residents and their family.

The residents' cultural, spiritual and individual values and beliefs are assessed on admission. Staff ensure that residents are informed and have choices related to the care they receive. Linkages with family and the community are encouraged and maintained. The service has a documented and implemented complaints management system.

## 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 organisation's mission statement and vision is documented. There is a current business plan and quality and risk management plan. Quality and risk management systems support service delivery and include internal audits, complaints management, resident and relative satisfaction surveys, and incident/accident management. Quality and risk management activities and responsibilities are shared among staff, residents and family. Policies have been reviewed.

The business and care manager is responsible for the overall management of the facility and is supported by the clinical manager and a regional and executive management team.

There are human resource policies implemented around recruitment, selection and orientation. Staffing is rostered to meet numbers of residents in the facility and acuity levels. The service has an information management system to ensure secure and safe management of resident and staff information. Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## 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 medium or high risk and/or unattained and of low risk.</p>
---	--	---

There is evidence that each stage of service provision is developed with resident and/or family input, coordinated to promote continuity of service delivery and within the required timeframes. Initial assessments and initial care plans are conducted on admission. The long term care plans for long term problems are individualised to reflect residents' needs and goals. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short term care plan.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The residents self-administering medicines do so according to policy.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines and additional requirements/modified needs are being met. There is a central kitchen and on site staff that provide the food service. The kitchen staff have completed food safety education.

## 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.
--	--	--

All building and plant comply with legislation, with a current building warrant of fitness in place. A maintenance programme includes equipment and electrical checks with any issues addressed as these arise. Fixtures, fittings, and floor and wall surfaces are made of accepted materials for this environment. Resident rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids.

The service has cleaning and laundry processes in place. The service is fit for the purpose, including the external environment.

Essential emergency and security systems are in place with regular fire drills completed. Call bells allow residents to access help when needed.

## 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 policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety. Staff education in restraint, de-escalation and challenging behaviour had been provided.

## Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control policies and procedures include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. Orientation in infection control is provided to all new employees and ongoing infection control education is available for all staff.

Staff are familiar with infection control measures at the facility. Residents are supported with infection control information as appropriate.

The type of surveillance undertaken is appropriate to the size and complexity of this service. Monthly surveillance is conducted and reported to staff and management. This information is also reviewed by the Oceania Care Company Limited clinical quality team and reported to the Oceania Care Company Limited board on a monthly basis.

## 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	47	0	2	1	0	0
<b>Criteria</b>	0	98	0	2	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)
<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>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their orientation to the service and through the training programme. Staff confirmed their understanding of the code. Examples are provided on ways the Code is implemented in their everyday practice, including maintaining residents' privacy, giving them choices, encouraging independence and ensuring residents can continue to practice their own personal values and beliefs. The information pack provided to residents on entry includes how to make a complaint, code of rights pamphlet and advocacy information. Education relating to the Code and complaints was last provided by Health and Disability Advocacy service, residents and families are invited to attend.</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 information pack includes information regarding informed consent. The registered nurse discusses informed consent processes with residents and their families/whānau during the admission process. Staff confirmed their understanding of informed consent processes.</p> <p>The informed consent policy and procedure directs staff in relation to gaining informed consent. This included guidelines for consent for resuscitation/advance directives. Staff ensure that all residents are aware of treatment and interventions planned for them, and that the resident and/or</p>

		<p>significant others are included in the planning of that care.</p> <p>All resident files identify that the required consents are collected.</p> <p>The general practitioner (GP) signs to state competence of the resident and the resuscitation status is ticked.</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>	FA	<p>Information on advocacy services through the Health and Disability Commissioner's (HDC) Office is provided to residents and families. Information on advocacy services is available at the entrance to the service.</p> <p>Staff training on the role of advocacy services is included in training on the Code with this provided annually to staff.</p> <p>Discussions with family and residents identified that the service provides opportunities for the family or enduring power of attorney (EPOA) to be involved in decisions. Resident files included 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>	FA	<p>There are no set visiting hours and family reported that they are encouraged to visit at any time. Residents confirmed that they are supported and encouraged to access community services with visitors or as part of the planned activities programme. The service also encourages the community to be a part of the residents' lives with visits from entertainers and 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>	FA	<p>The service's complaints policy and procedures are in line with the Code and includes timeframes for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint was received; the source of the complaint; a description of the complaint; and the date the complaint was resolved. The complaints policy is included in the information pack given to residents on admission. Residents and family member stated that they would feel comfortable complaining.</p> <p>There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The Code and information on the advocacy service is available and displayed in English and te reo Māori in the foyer and other areas in the facility. The admission information packs reviewed included information on the Code, advocacy and complaints processes. Interviews confirmed explanations regarding their rights occurred on admission. The business care manager (BCM) clinical manager (CM) and registered nurses (RNs) follow up with a discussion with residents and families during the admission process. Residents and family members interviewed confirmed they were provided with information regarding the Code and the Nationwide Health and Disability Advocacy Service prior to admission. The completed resident and family surveys indicated residents are aware of their rights and are satisfied with this aspect of service delivery.</p> <p>Residents and family interviewed received copies of the Oceania handbook. Families and residents are informed of the range of services. This is included in the service agreement and admission agreements.</p> <p>Residents interviewed confirmed they had access to an advocate if needed. The BCM advised that an advocate visits the facility on a regular basis and is also responsible for taking resident meetings.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. This is supported with policies and procedures that are aligned with the requirements of the Privacy Act and Health and Information Privacy Code. Initial and ongoing assessments to ascertain details of people's beliefs and values are completed with the resident and family members. Interventions to support these are identified and evaluated. Residents and family confirmed that they are included in the care planning process and are addressed by their preferred name. Caregivers state that they support the residents' independence by encouraging them to be as active as possible. The residents' own personal belongings are used to decorate their rooms.</p> <p>Discussions of a private nature are held in the resident's room and not in public areas; there are areas in the facility which can be used for private meetings. Caregivers reported that they knock on bedroom doors prior to entering rooms, signs are placed on the closed door, indicating cares are been given. This was observed on the days of the audit. Residents and families confirmed that their privacy is respected.</p> <p>Staff have had education around abuse and neglect in 2016 and are able to describe the reporting process should any be identified. Family, staff, residents and the general practitioner stated that there is no evidence of abuse and neglect.</p> <p>Residents are supported to access spiritual support when needed and there are</p>

		interdenominational services at least weekly.
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service implements the Māori Health Plan and cultural safety procedures to eliminate cultural barriers. The rights of the residents/whānau to practise their own beliefs are acknowledged in the Māori Health Plan. The diversional therapist completes the cultural assessments on admission and updates six monthly.</p> <p>The Māori advisor for MidCentral DHB (MCDHB) attends the three monthly DHB portfolio managers meetings and is available for consultation for the service. There are four residents who identify as Māori, living at the facility and a cultural assessment has been completed. Interviews with residents and family confirm their cultural needs are being met. Cultural training for staff has been provided 2016.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family are involved in the assessment and the care planning processes, confirmed in interviews with residents and families. Information gathered during assessment includes the resident's cultural values and beliefs. The service had residents from other cultures who, during interview confirmed that their cultural needs are met. Staff and family interviews confirm that the service take additional care in making sure cultural needs of residents are identified and met. The auditors verified cultural assessments for residents.</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>Staff files have job descriptions and employment agreements that have clear guidelines regarding professional boundaries. Families and residents expressed no concerns with breaches in professional boundaries, discrimination or harassment. Staff orientation and their employee agreement include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the caregivers' role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>A staff education programme is implemented and staff can describe sound practice based on policies and procedures, care plans and information given to them via the registered nurses (RNs) and general practitioner (GP).</p> <p>Consultation is also available with health professionals and specialists in the region with staff able to describe how and when they can make contact. Residents and families interviewed expressed a high level of satisfaction with the care delivered.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guided staff on the process to ensure full and frank open disclosure was available. Family members confirmed that they are informed if the resident has an incident, accident, or has a change in health or needs. Family contact is recorded in residents' files.</p> <p>Interpreting services are available from the district health board. Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident.</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>	FA	<p>The Oceania Care Company Limited's vision, values, mission statement and philosophy are displayed at the entrance to the facility. The organisation has systems in place recording the scope, direction and goals of the organisation. The business and care manager (BCM) provides monthly status reports to the support office. These reports include quality and risk management issues, occupancy, human resource issues, quality improvements, internal audit outcomes and clinical indicators</p> <p>The BCM is supported by the clinical quality manager. The clinical manager's (CM) appointment is full time and is responsible for all clinical matters. The CM has worked for the organisation for several years. The BCM has worked in the organisation for 15 years. The BCM has a business management background.</p> <p>The facility can provide care for residents requiring rest home or hospital level of care. Occupancy during the onsite audit was 44 residents. On the day of audit there were 27 residents requiring hospital level care, including three residents under the young person disability (YPD) contract for under 65 year old residents. There were 17 rest home residents of which includes one resident under the YPD contract.</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</p>	FA	<p>There are appropriate systems in place to ensure the day-to-day operation of the service continues should the BCM be absent. The CM assumes the role and is supported by the clinical team leaders and the support office.</p>

services to consumers.		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Palmerston Manor uses the Oceania Care Company Limited (Oceania) quality and risk management framework that is documented to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required, with all policies current. The support office reviews all policies, with input from business and care managers. Policies are linked to the Health and Disability Sector Standard, current and applicable legislation, and evidenced-based best practice guidelines. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to say that they have read and understood. Staff interviewed stated they read any new or revised policies and all sign a form indicating that they have read and understood policies. All clinical staff interviewed reported they are kept informed of quality improvements.</p> <p>There are monthly joint staff/quality and joint health and safety/infection control meetings held, that include all aspects of the quality programme. There are monthly resident meetings with family able to attend if they choose to. The meetings have agendas; however corrective action timeframes completion dates and sign off were not always recorded.</p> <p>Service delivery is monitored through review of complaints, review of incidents and accidents with monthly analysis of data, surveillance of infections, and implementation of an internal audit programme. Corrective action plans are documented and evidence of resolution of issues are documented when these are identified.</p> <p>Risks are identified, and there is a hazard register that identifies health and safety risks as well as risks associated with human resource management, legislative compliance, contractual risks and clinical risk.</p> <p>Resident/family satisfaction surveys are completed six monthly and results documented from the 2016 survey indicate that residents and family are very happy with the service and environment with minimal suggestions for improvement.</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</p>	FA	<p>Staff document adverse, unplanned or untoward events on an accident/incident form. Families are being informed after adverse events, confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the business and care manager (BCM). Corrective action plans address areas requiring improvement and are documented. There is an open disclosure policy.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events through: job descriptions and policies and procedures. Policy and procedures meet</p>

<p>open manner.</p>		<p>the terms of essential notification reporting for example: health and safety, human resources and infection control.</p> <p>Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events and their responsibilities relating to essential notification. .</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>Written policies and procedures in relation to human resource management are available. The skills and knowledge required for each position is documented in job descriptions which outlines accountability, responsibilities and authority. These are reviewed on staff files along with employment agreements, reference checking, criminal vetting, drug testing, completed orientations and competency assessments.</p> <p>Copies of annual practising certificates are reviewed for all staff that require them to practice and are current. The clinical leader is responsible for the in-service education programme. Competency assessment questionnaires are available and completed competencies were reviewed. Staff are supported to complete education via external education providers. An appraisal schedule is in place and current staff appraisals were sighted on all staff files reviewed.</p> <p>An orientation/induction programme is available and new staff are required to complete this prior to their commencement of care to residents. The business and care manager advised that staff complete orientation and induction at employment. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end of this period. Orientation for staff covers the essential components of the service provided. Care staff interviewed confirmed they have completed an orientation, including competency assessments.</p> <p>The service has six registered nurses who have completed InterRAI training.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented rationale in place for determining service provider levels and skill mixes in order to provide safe service delivery. Registered nurses (RNs) cover is 24 hours a day.</p> <p>On call after hours registered nurse support and advice is provided by business and care manager (BCM) and clinical manager (CM). Care staff interviewed reported adequate staff is available and that they are able to get through their work. Residents and family interviewed report staff provide them with adequate care.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>Residents' information is stored securely in staff areas. Clinical notes are current and accessible to all clinical staff; information containing sensitive resident information is not displayed in a way that it could be viewed by other resident's medical care or members of the public. Entries are legible, dated and signed by the relevant healthcare assistant, registered nurse or other staff member, including designation. Approved abbreviations are listed.</p> <p>The service retains relevant and appropriate information to identify and track resident's records. There is sufficient detail in resident's files to identify resident's ongoing care, history, and activities. Documentation in individual resident files demonstrated service integration. The resident's national health index (NHI) number, name, date of birth and general practitioner are used as the unique identifier. Clinical staff interviewed confirmed they know how to maintain confidentiality of resident information.</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>	<p>FA</p>	<p>When the need for service has been identified, it is planned, co-ordinated and delivered in a timely and appropriate manner. Entry and assessment processes are recorded and implemented. The facility information pack is available for residents and their family and contains all relevant information.</p> <p>The admission agreement defines the scope of the service and includes all contractual requirements. The InterRAI assessments are completed for rest home and hospital level of care, prior to entry to the facility. In interviews, residents and family confirmed the admission process was completed by staff in timely manner, all relevant admission information was provided and discussion held with staff in respect of resident care have been conducted.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	<p>FA</p>	<p>There is appropriate communication with resident, family and other providers, that demonstrate transition, exit, discharge or transfer plans are communicated, when required.</p> <p>Exit, discharge or transfer is managed in a planned and co-ordinated manner. At the time of transition appropriate information is supplied to the person/facility responsible for the ongoing management of the resident. All referrals are documented in residents' progress notes.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a</p>	<p>PA Low</p>	<p>Medication areas, including controlled drug storage evidenced an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidenced weekly checks and six monthly</p>

<p>safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>		<p>physical stocktakes. The medication fridge temperatures are conducted and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The staff observed demonstrated knowledge and understanding of their roles and responsibilities related to each stage of medicine management, however the location of the hospital controlled drug storage key requires compliance with legislation and guidelines. Staff education in medicine management was conducted.</p> <p>Residents' medication charts are recorded on Medi-Map computerised system. The residents self-administering medicines at the facility do so according to policy, which complies with legislation and guidelines.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food service policies and procedures are appropriate to the service setting with a seasonal menu reviewed by a dietitian.</p> <p>A dietary assessment is undertaken for each resident on admission to the facility and a dietary profile developed. The personal food preferences of the residents, special diets and modified nutritional requirements are known to the cook and accommodated in the daily meal plan. Special equipment, to meet resident's nutritional needs, was sighted.</p> <p>The cook confirmed they were aware of the residents' individual dietary needs. There were current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if resident's dietary requirements change, confirmed at interview with the cook. The residents' files demonstrate monthly monitoring of individual resident's weight.</p> <p>All aspects of food procurement, production, preparation, storage, transportation, delivery and disposal complies with current legislation and guidelines.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>The residents would be declined entry if not within the scope of the service or if a bed was not available. A process exists for informing residents, their family and their referrers if entry is declined. The reason for declining entry would be communicated to the referrer, resident and their family or advocate in a timely and compassionate format that was understood. Where requested, assistance would be given to provide the resident and their family with other options for alternative health care arrangements or residential services.</p>
<p>Standard 1.3.4: Assessment</p>	<p>PA</p>	<p>On admission, residents' needs are identified through a variety of information sources which</p>

<p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>Moderate</p>	<p>include: the needs assessment and service coordination (NASC) agency; other service providers involved with the resident; the resident; family; general practitioner (GP) and on-site assessments using a range of assessment tools. The InterRAI assessments are completed within the required timeframe post admission to the facility. The residents' needs, outcomes and goals are identified via the assessment process and recorded.</p> <p>The residents' files evidenced residents' discharge/transfer information from the district health board where required. The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the GP. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care.</p> <p>Review of the wounds at the facility evidenced the wound care assessments are not consistently recorded when required.</p>
<p>Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	<p>FA</p>	<p>The residents' long term care plans are individualised, integrated and up to date. The care plan interventions reflect the risk assessments and the level of care required. Short term care plans are developed, when required and signed off by the RN when problems are resolved (refer to criterion 1.3.4.2). The residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview.</p> <p>Care plans evidence service integration with progress notes, activities notes, and medical and allied health staff records documented.</p>
<p>Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The residents' long term care plans evidenced interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records were current. In interviews, residents and family confirmed their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated.</p> <p>There were sufficient supplies of equipment seen to be available that complied with best practice guidelines and met the residents' needs.</p>
<p>Standard 1.3.7: Planned Activities</p>	<p>FA</p>	<p>In interview, the diversional therapist (DT) confirmed the activities programme meets the needs of the service group and the service has appropriate equipment. The DT plans, implements and</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>evaluates the activities programme. There is one activities programme for the rest home and hospital residents. Residents are assessed on admission to ascertain their needs and appropriate activity and social requirements. There are current, individualised activities care plans in residents' files. Activities care plans are evaluated six monthly.</p> <p>The activities programmes include input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. The residents' activities attendance records are maintained. The residents' meeting minutes evidenced residents' involvement and consultation of the planned activities programme. Residents confirmed their satisfaction with the activities programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Timeframes in relation to care planning evaluations are documented. Formal care plan evaluations, following reassessments, including InterRAI, to measure the degree of a resident's response in relation to desired outcomes and goals occur every six months or as residents' needs change and are carried out by the RN. There was evidence of resident, family, health care assistants, diversional therapist and GP input in care plan evaluations. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>Resident care is evaluated on each shift and reported in the progress notes. If any change is noted, it is reported to the RN. Short term care plans are in some of the residents' files and are used when required. Short term care plans are reviewed daily, weekly or fortnightly as indicated by the degree of risk noted during the assessment process. The family are notified of any changes in resident's condition, confirmed at family interviews.</p> <p>There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	<p>FA</p>	<p>Appropriate processes are in place to provide choices for residents in accessing or referring to other health and/or disability services. Family communication sheets confirmed family involvement. An effective multidisciplinary team approach is maintained and progress notes detail relevant processes are implemented.</p> <p>When referral for non-urgent service is indicated or requested, a referral is sent to the appropriate health care professional. When the need for urgent referral is identified this is attended to by sending the resident to accident and emergency in an ambulance if the circumstances dictate.</p>

<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	<p>FA</p>	<p>Documented processes for the management of waste and hazardous substances are in place and the hazard register is current. Policies and procedures for chemicals specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and free from damage. Material safety data sheets are available throughout the facility and accessible for staff. Staff receive training and education to ensure safe and appropriate handling of waste and hazardous substances. Interviews with the household staff confirmed this.</p> <p>There is provision and availability of personal protective clothing and equipment including: goggles/visors; gloves; aprons; footwear; and masks. During a tour of the facility, personal protective clothing and equipment was observed in areas where there are risks.</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>A current building warrant of fitness is displayed. The service has a planned maintenance schedule implemented with a test and tag programme. Checking and calibration of clinical equipment is completed annually.</p> <p>The service upgraded and redecorated all the rooms and upgraded the garden areas. On the day of the site visit, two thirds of the resident's rooms had been painted. There have been no building modifications since the last audit. Interviews with staff and observation of the facility confirmed there is adequate equipment including: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet providing privacy when required. There is an outside area with shade, seating and outdoor tables. There are ramps and rails at entrance doors for access for residents with disabilities.</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 adequate numbers of accessible toilets/bathing facilities. Visitors' toilets and residents' toilets are located close to communal areas. All the toilets have a system that indicates if it is engaged or vacant.</p> <p>All the residents' toilets and bathing areas have handrails and other equipment/accessories to enhance and promote residence independence.</p> <p>Residents and family members report that there are sufficient toilets and showers with some rooms in the rest home/hospital area having their own ensuite. Auditors observed residents being supported to access communal toilets and showers in ways that are respectful and dignified.</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>	FA	<p>There is adequate personal space in all the bedrooms to allow residents and staff to safely move around in the room. Equipment was sighted in hospital rooms needing this, with sufficient space for both the equipment and at least two staff and the resident, for example hoists and wheel chairs. The residents' rooms are personalised with furnishings, photos and other personal possessions. Residents and families are encouraged to make the room their own.</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 needs.</p>	FA	<p>The service has lounges and dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, when required. Furniture is appropriate to the setting and arranged in a manner which enabled residents to mobilise freely. There is furniture in the garden areas and designated parking spaces for the mobility scooters.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>The laundry services are completed on site. There are designated clean and dirty areas in the laundry with separate doors to take clean and dirty laundry in and out. Laundry staff are required to return linen to the rooms. The linen trolleys are clearly labelled to identify resident's individual laundry and general laundry. The laundry staff interviewed confirmed knowledge of their role including management of any infectious linen.</p> <p>There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and the cleaners are aware that the trolley must be with them at all times. Cleaners were observed on the days of the audit keeping the cleaning trolley in sight. All chemicals are in appropriately labelled containers. Laundry chemicals are administered through a closed system which is managed by a chemical contractor company. Products are used with training around use of products provided.</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>An evacuation plan has been approved by the New Zealand Fire Service. An evacuation policy on emergency and security situations is in place. Fire drills are completed six monthly. The orientation programme includes fire and security training. Checking the fire exits daily for clearance is on the maintenance daily schedule. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>A civil defence plan is in place. There are adequate supplies in the event of a civil defence</p>

		<p>emergency including: food; water; blankets; emergency lighting and gas BBQs. An electronic call bell system utilises a pager system. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways, dining rooms. Call bell audits are routinely completed and residents and family state that there are prompt responses to call bells.</p> <p>External doors leading to the gardens and outside doors are locked after sunset, these doors can only be opened from the inside. Staff complete a security check of all outside doors in the evening that confirms that security measures are in place.</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>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. Monthly room temperature checks are monitored. There is a designated external smoking area.</p> <p>Family and residents stated that the building is maintained at an appropriate temperature in both winter and summer.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The Oceania infection prevention and control policies and procedures manual provides information and resources to inform staff on infection prevention and control.</p> <p>The responsibility for infection control is clearly defined in the infection control policy that includes: responsibilities of the Oceania infection control committee (company –wide); infection control nurse and the infection control team. There is a signed infection control nurse’s (ICN) job description outlining responsibilities of the position. Infection related information is communicated to staff and management. The facility’s infection control programme is reviewed annually.</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>There is relevant and current information on infection prevention and control, which is appropriate to the size and complexity of the service, including but not limited to: infection control manual; internet; access to experts; and education. Infection control is an agenda item at the facility’s meetings, evidenced during review of meeting minutes and interviews with staff.</p> <p>The implementation of the infection control programme is monitored via internal audits and Oceania benchmarking reports.</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>	<p>FA</p>	<p>The Oceania infection control committee (company-wide) develop and review the infection control policies and procedures to be implemented within the Oceania facilities. They are developed and reviewed annually in consultation and input from relevant staff, and external specialists. The policies and procedures are up to date, reflect current accepted good practice and relevant legislative requirements. The infection control manual is readily accessible to all personnel, confirmed at staff interviews.</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>	<p>FA</p>	<p>The infection control education is provided to all staff, as part of their orientation and as part of the ongoing in-service education programme. The ongoing infection control education has occurred during 2016. Education sessions have evidence of staff attendance/participation and content of the presentations. The ICN has conducted infection control education relevant to their role. Hand hygiene is part of the orientation process prior to commencement of work. Hand hygiene competencies are reviewed by staff annually and as deemed appropriate. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.</p> <p>In interviews, staff advised that clinical staff identify situations where infection control education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events, indicators or outcomes. Infection logs are maintained for infection events. Monthly surveillance analysis is completed and entered in the clinical indicators report on the Oceania intranet. This information is reviewed by the Oceania clinical quality team and reported to the Oceania board on a monthly basis.</p> <p>Residents' files evidenced the residents' who were diagnosed with an infection had short term care plan in place.</p> <p>In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the clinical manager (CM) and the RN's, verbal handovers, short term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the</p>

		<p>residents' files.</p> <p>In interview, the CM confirmed an outbreak occurred at the facility in July 2015. The Ministry of Health was notified. The required notifications occurred for this outbreak.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler in the policy is congruent with the definition in the standard. The process of assessment, consent, care planning, monitoring and evaluation of restraint and enabler use is recorded and implemented. There were four residents at the facility using enablers and three residents using restraint on the days of the audit. The restraint and enabler use were documented in residents' files reviewed.</p> <p>The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.</p> <p>National restraint benchmarking and analysis is reviewed monthly by the Oceania Care Company Limited clinical and quality managers and the results indicate there has been reduction in restraint used nationally due to use of low/low beds and the use of perimeter mattress surrounds.</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 Oceania Care Company Limited (Oceania) clinical and quality team are responsible for approving any form or type of restraint practice used at Oceania facilities nationally. Oversight of restraint use at each individual Oceania facility is the responsibility of restraint coordinators. The restraint coordinator at Palmerston Manor is the clinical manager. The responsibilities for this role are defined in the position description. The restraint approval group is defined in the restraint minimisation and safety policies and procedures.</p> <p>Restraints are authorised following a comprehensive assessment of the resident. The approval includes consultation with other members of the multidisciplinary team. The restraint consent forms evidence consent for restraint is obtained from the GP, the restraint coordinator and the resident and/or a family member. Health care assistants are responsible for monitoring and completing restraint forms when restraints are in use.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	FA	<p>Restraint assessment is completed prior to commencement of any restraint. The clinical files of residents using restraint evidenced the restraint assessment authorisation and plans were in place. Restraint assessments evidenced the restraint coordinator's sign off and evidence all appropriate</p>

undertaken, where indicated, in relation to use of restraint.		factors have been taken into consideration.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	<p>Policies and procedures on safe use of restraint detail the processes of assessment, approval and implementation and these guide staff in the safe use of restraint. Strategies are implemented prior to use of restraint to prevent the resident from incurring injury for example: the use of low beds; mattresses and sensor mats. Restraint consents are signed by appropriate staff and family/resident.</p> <p>Staff training and education in restraint use includes appropriate orientation and ongoing education. Evidence of ongoing education regarding restraint and challenging behaviours was evident. Restraint competency testing of staff is included in the education of staff.</p> <p>The restraint register is up to date and records all necessary information to provide an auditable trail of restraint events.</p>
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	<p>Evaluation of restraint occurs through restraint event reporting by Palmerston Manor management to the Oceania support office by measuring relevant clinical key performance indicators. Each individual episode of restraint is evaluated. The clinical files of residents using restraint evidenced the restraint evaluation forms were completed and included all the relevant factors in this standard.</p> <p>The restraint minimisation team meeting minutes evidenced evaluation of each restraint use at the facility.</p> <p>The resident (if able) and the family are involved in the evaluation of the restraints' effectiveness and continuity. Documentation was sighted in the residents' files regarding restraint related matters.</p>
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>There is evidence of monitoring and quality review of use of restraints at the facility. The restraint minimisation team meeting minutes evidence review of the compliance with the standard and includes: individual resident's restraint review; restraint register update; education review and any relevant restraint issues. Restraint use audits are conducted and include review of residents' clinical files of residents who use restraint.</p> <p>Oceania's national restraint authority group terms of reference are recorded. This group meet annually to review the compliance with the restraint standard and review of restraint use nationally.</p>

## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	<p>Corrective action plans are in place with incident/accident and complaints. however they were not always recorded in the meeting minutes with the designated person responsible for the implementation of the corrective action, timeframes, completion dates and sign off.</p>	<p>Review of meeting minutes evidenced that improvement is required as they did not consistently have a corrective action, designated person responsible, timeframes</p>	<p>Ensure that all improvements identified as being required have a corrective action plan documented or evidence of resolution of issues.</p> <p>180 days</p>

			and sign off.	
<p>Criterion 1.3.12.1</p> <p>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>	PA Low	<p>The hospital medication room has access via a key pad lock. The key to the controlled drug storage was located on a shelf in the hospital medication room for RNs to access when required. The clinical manager stated only RNs have access to the hospital medication room. Discussion were held with the business and care manager, the clinical manager and the regional clinical and quality manager on first day of audit regarding the location of the controlled drug key. On second day of the audit, the audit team were presented with a corrective action plan relating to the controlled drug key location. The corrective action plan recorded; RNs were informed (documented in diary) that the controlled drug key was to be carried by the senior person on duty at all times as per policy and medication guides; notice sent to all RNs informing them of their responsibilities and a time target message sent to all RNs. The new process commenced on the second day of audit.</p>	<p>Incorrect placement and storage of the controlled drug key.</p>	<p>Ensure the controlled drug keys procedure is implemented and embedded within the organisation.</p> <p>30 days</p>
<p>Criterion 1.3.4.2</p> <p>The needs, outcomes, and/or goals of consumers are identified via the assessment process and are documented to serve as the basis for service delivery planning.</p>	PA Moderate	<p>Review of residents' documentation relating to wound care evidenced, when wounds were identified they were recorded on short term care plans and reviewed depending on the frequency of review recorded on the plan. The initial wound assessments were not undertaken for all wounds identified. Assessments were not carried out at each dressing change and not documented on the wound assessment and monitoring form, instead brief comments (not assessments) regarding the wound were recorded on the short term care plan.</p>	<p>Wound care initial assessments and subsequent regular assessments are not consistently completed and recorded.</p>	<p>Provide evidence initial assessments and subsequent regular assessments of wounds are completed and recorded.</p> <p>60 days</p>

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

---

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

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

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

No data to display
--------------------

End of the report.