# Ambridge Rose Villa Limited

## Introduction

This report records the results of a Provisional 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](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Ambridge Rose Villa Limited

**Premises audited:** Marvon Downs Rest Home

**Services audited:** Rest home care (excluding dementia care)

**Dates of audit:** Start date: 17 December 2014 End date: 17 December 2014

**Proposed changes to current services (if any):** None

**Total beds occupied across all premises included in the audit on the first day of the audit:** 31

# 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.

## General overview of the audit

Marvon Downs is certified to provide rest home level care for up to 31 residents. On the day of the audit there were 30 residents. Marvon Downs is privately owned. There are three improvements required around chemical safety training, aspects of medication management and environmental restraint.

The provisional audit was undertaken to establish the preparedness of the prospective provider and establish the level of conformity of the existing provider’s service under offer. The prospective owners have experience in managing an aged care facility and also own and manage another aged care facility. A transitional plan has been developed around change of ownership and management.

The prospective owner reported the current policies, systems and staff (except management) will remain in place following the purchase. A new facility manager (experienced aged care registered nurse) will commence at Marvon Downs. The management team of Ambridge Rose Manor Limited will oversee all operational aspects of Ambridge Rose Villa Ltd t/a Marvon Downs Rest Home and provide support to the facility manager.

## Consumer rights

Staff demonstrate an understanding of residents' rights and obligations. This knowledge is incorporated into their daily work duties and caring for the residents. Residents are treated with respect. They receive services in a manner that considers their dignity, privacy and independence. Written information regarding consumers’ rights is provided to residents and families. Residents' cultural, spiritual and individual values and beliefs are assessed on admission. A Maori health plan is incorporated into the delivery of services for Maori residents. Evidence-based practice is evident, promoting and encouraging good practice. A policy on open disclosure is in place. There is evidence that residents and family are kept informed. The rights of the resident and/or their family to make a complaint is understood, respected and upheld by the service. A system for managing complaints is in place.

## Organisational management

Services are planned, coordinated, and appropriate to the needs of the residents. A manager/owner and clinical nurse manager (registered nurse) are responsible for the day-to-day operations. Quality and risk management processes are maintained, reflecting the principals of continuous quality improvement. Quality goals are documented for the service. Corrective action plans are implemented where opportunities for improvement are identified. A risk management programme is in place, which includes a risk management plan, incident and accident reporting, and health and safety processes. Adverse, unplanned and untoward events are documented by staff. Residents receive appropriate services from suitably qualified staff. Human resources are managed in accordance with good employment practice, meeting legislative requirements. A comprehensive orientation programme is in place for new staff. An education and training programme for staff is in place. A required improvement is around staff training on chemical safety. Two nurses are employed, which includes a full-time clinical nurse manager and a part time registered nurse. There are adequate numbers of staff on duty to ensure residents are safe. The residents’ files are appropriate to the service type and demonstrate service integration.

## Continuum of service delivery

Resident files demonstrate implemented systems to assess, plan and evaluate care needs of the residents. Care plans are reviewed six monthly, or when there are changes in the residents’ health status. Resident files include notes by the GP and allied health professionals. Communication with family is documented. Planned activities are appropriate to the residents' interests and residents confirm their satisfaction with the programme. Activity plans including goals and interventions are completed and evaluated six monthly. Individual activities are provided either within group settings or on a one-on-one basis. Activities are planned monthly. An appropriate medicine management system is implemented and staff responsible for medicine management complete annual competencies. Medication charts sighted evidence documentation of three monthly medication reviews completed by general practitioners. There is a required improvement around medication management. Food services are managed by a chef, and all food is cooked on site. Staff involved with food services have attained safe food handling certificates. Residents and families interviewed, all confirmed satisfaction with food services.

## Safe and appropriate environment

The building has an approved fire evacuation plan. All required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are emergency policies and procedures in place to guide staff should an emergency or civil defence event occur. There is a minimum of one staff on duty at all times who holds a current first aid certificate.

## Restraint minimisation and safe practice

The restraint management policy and staff state that enablers should be voluntary and the least restrictive option. There are no residents that require enablers and restraint is not used in the service with the exception of environmental restraint, which is place via gated entry to the grounds with key pad access. There is one required improvement around ensuring restraint processes are implemented for any residents whose freedom of movement is restricted as a result of environmental restraint.

## Infection prevention and control

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 (clinical nurse manager) is responsible for coordinating education and training for staff. The infection control co-ordinator has attended external training. There are a suite of infection control policies and guidelines to support practice. Appropriate training of staff is included as part of the programme. The infection control co-ordinator uses the information obtained through surveillance to determine infection control activities and education needs within the facility. This includes audits of the facility, hand hygiene and surveillance of infection control events and infections.

## Summary of attainment

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

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Attainment Rating** | **Continuous Improvement****(CI)** | **Fully Attained****(FA)** | **Partially Attained Negligible Risk****(PA Negligible)** | **Partially Attained Low Risk****(PA Low)** | **Partially Attained Moderate Risk****(PA Moderate)** | **Partially Attained High Risk****(PA High)** | **Partially Attained Critical Risk****(PA Critical)** |
| **Standards** | 0 | 42 | 0 | 3 | 0 | 0 | 0 |
| **Criteria** | 0 | 90 | 0 | 3 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

For more information on the different types of audits and what they cover please click [here](http://www.health.govt.nz/your-health/services-and-support/health-care-services/services-older-people/rest-home-certification-and-audits).

|  |  |  |
| --- | --- | --- |
| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.1: Consumer Rights During Service DeliveryConsumers receive services in accordance with consumer rights legislation. | FA | Staff receive training on the Code of Health and Disability Services Consumers’ Rights (the Code) during their induction to the service and through the on-going education and training programme. Interviews with staff (three of three healthcare assistants, one clinical nurse manager) confirm their understanding of the Code. The most recent in-service training was provided on 5 March 2013. Examples were provided by staff on ways the principals of the Code are 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. |
| Standard 1.1.10: Informed ConsentConsumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent. | FA | In the six files were reviewed there were signed consents to share information, for photographs, for obtaining a nursing history and for an annual flu vaccine. The clinical nurse manager informs family are involved during the consent process. Consents were signed by the resident or their EPOA. EPOA documents are kept on the resident's file. In the six files reviewed informed consent is evident for resuscitation orders. Resuscitation orders are reviewed annually.Six residents interviewed confirm they are given good information to be able to make informed choices. Three healthcare assistants and the clinical nurse manager confirm information is provided to residents prior to consent being sought and they are able to decline or withdraw their consent. Policies and training support staff in providing care so residents can make choices and be involved in the service (training last provided May 2014). There is an informed consent policy and procedure that directs staff clearly in relation to the gathering of informed consent. Interview with three healthcare assistants inform consent is sought in the delivery of personal cares and this is confirmed by six residents interviewed. D13.1 There were six of six admission agreements sighted.D3.1.d Discussion with five family identified that the service actively involves them in decisions that affect their relative’s lives. |
| Standard 1.1.11: Advocacy And SupportService providers recognise and facilitate the right of consumers to advocacy/support persons of their choice. | FA | Information on Advocacy Services through the Health and Disability Commissioner’s (HDC) Office is included in the resident information pack that is provided to residents and their family on admission. Pamphlets on advocacy services are available at the entrance to the facility. Interviews with residents and families confirm their understanding of the availability of advocacy services. Staff receive two-yearly education and training on the role of advocacy services. Advocacy services have not been required as a result of any lodged complaints. |
| Standard 1.1.12: Links With Family/Whānau And Other Community ResourcesConsumers are able to maintain links with their family/whānau and their community.  | FA | The service has an open visiting policy. Residents may have visitors of their choice at any time. The service encourages the residents to maintain their relationships with their friends and community groups by continuing to attend functions and events, and providing assistance to ensure that they are able to participate in as much as they can safely and desire to do. Residents have access to various community services. They were observed freely entering and exiting the service, attending voluntary work commitments, catching the public bus for transport to the shopping centre, and attending local community groups (e.g., coffee groups, Retired Services Association). A newsletter is printed two monthly, which is distributed to residents and their families. Resident meetings are held every two months (meeting minutes sighted).  |
| Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.  | FA | D13.3h. A complaints procedure is provided to residents and families in the information pack at entry, which includes the telephone contact details for the Health and Disability Commissioner. The service seeks suggestions to improve conditions for the residents. Complaints forms are readily available. A complaints flowchart is in place. There is a complaints register that is up to date and includes relevant information regarding any lodged complaints. Discussions with all six residents and five relatives confirm they are provided with information on complaints and complaints forms. Family report that if they have a concern, it is dealt with in a prompt manner by the manager/owner or the clinical nurse manager.The complaints register was reviewed. Eight complaints have been lodged in 2014 (year to date). All lodged complaints reflect the complaint being acknowledged, an investigation process and sign-off by the manager/owner when the complaint has been resolved. No complaints have been lodged with the Health and Disability Commissioner. Several complaints lodged were verbal, relating to items lost by the resident and later found.D13.3h. A complaints procedure is provided to residents within the information pack at entry.Three of three healthcare assistants are able to describe the complaints process. |
| Standard 1.1.2: Consumer Rights During Service DeliveryConsumers are informed of their rights. | FA | Details relating to the Code are included in the resident information pack that is provided to new residents and their family. The manager/owner and/or the clinical nurse manager discuss aspects of the Code with residents and their family on admission. An explanation of the complaints process is also contained in the resident admission agreement. Discussions relating to the Code are held during the two-monthly residents' meetings. The Code was last reviewed with the residents on 23 July 2014. Six of six residents and five of five relatives interviewed report the residents’ rights are being upheld by the service. |
| Standard 1.1.3: Independence, Personal Privacy, Dignity, And RespectConsumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence. | FA | The service ensures that the residents’ right to privacy and dignity is recognised and respected at all times. The residents’ personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident’s room. Three of three healthcare assistants interviewed report that they knock on bedroom doors prior to entering rooms, ensure doors and curtains are shut when cares are being given and do not hold personal discussions in public areas. One shower lacked visual privacy with only a curtain used instead of a door. The door was reinstalled during the audit. All six residents and five relatives interviewed confirm the residents’ privacy is respected. All three healthcare assistants interviewed report that they encourage the residents' independence by encouraging them to be as active as possible. Guidelines on abuse and neglect are documented in policy. There have been no reported instances of abuse or neglect at the facility. Staff receive mandatory education and training on abuse and neglect, which was last provided on 11 February 2014. Three of three healthcare assistants interviewed are aware of the signs of abuse and neglect.  |
| Standard 1.1.4: Recognition Of Māori Values And BeliefsConsumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs. | FA | The service is committed to ensuring that the individual interests, customs, beliefs, cultural and ethnic backgrounds of Maori are valued and fostered within the service. They value and encourage active participation and input of the family/whanau in the day-to-day care of the resident. Cultural values and beliefs are documented in the resident’s care plan. A family member reports that her relative’s cultural needs are being met by the service. This includes (but is not limited to) food choices and the involvement of whanau. Maori consultation is available through the Counties Manukau District Health Board. Staff receive education on cultural awareness during their induction and as an in-service topic. The most recent Maori cultural education in-service took place on 2 October 2014. The three healthcare assistants interviewed are aware of the importance of whanau in the delivery of care for Maori residents. |
| Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And BeliefsConsumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.  | FA | The service identifies each resident’s personal needs and desires from the time of admission. This is achieved with the resident, family and/or their representative. Beliefs and values are discussed and incorporated into the care plan, sighted in all six care plans reviewed. Family are encouraged to be involved in the development of the resident’s long term care plan. Six of six residents and five of five family members interviewed confirm they are involved in developing a plan of care for their family member, which includes the identification of individual values and beliefs. |
| Standard 1.1.7: DiscriminationConsumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation. | FA | All staff have a position description to describe their working boundaries in caring for the residents. A staff code of conduct, house rules and conflict of interest are clearly defined in the policies and procedures and are discussed during the induction process. Professional boundaries are also included in the staff performance appraisal process. Interviews with three of three healthcare assistants confirm their understanding of professional boundaries, including the boundaries of the healthcare assistants’ role and responsibilities. Professional boundaries are reconfirmed through monthly education and training sessions and staff meetings. |
| Standard 1.1.8: Good PracticeConsumers receive services of an appropriate standard. | FA | Evidence-based practice is evident, promoting and encouraging good practice. A clinical nurse manager (registered nurse) is available four days a week. A staff registered nurse is onsite every Saturday and on alternate Sundays. Residents are reviewed by the general practitioner (GP) every three months. The service receives support from Counties Manakau District Health Board (CMDHB) which includes regular visits from the CMDHB Mental Health Services for the Older Person nursing and psychology staff. A gerontology nurse specialist visits as required. Physiotherapy services are available on an as-needed basis. There is a regular in-service education and training programme for staff. A podiatrist is onsite every two months and a hairdresser is available once a week. The service has links with the local community and encourages residents to remain independent.The manager/owner reports that staff turnover is very low. Many staff including healthcare assistants have worked at Marvon Downs for a significant period of time.Six of six residents and five of five families interviewed expressed their satisfaction with the care delivered. The GP interviewed is also satisfied with the level of care that is being provided. |
| Standard 1.1.9: CommunicationService providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | There is a resident support and communication policy. 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.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, which is consistent for all residents including those who pay privately for services. D16.4b Five of five relatives report that they are always informed when their family member’s health status changes.D11.3 The information pack is available in large print and can be read to residents.A specific policy to guide staff on the process of full and frank open disclosure is available. Accident/incidents, the complaints procedure and the open disclosure policy alert staff to their responsibility to notify family/next of kin. The incident form includes space to document that family were informed of the event. Family were contacted in all 15 incident forms reviewed. Discussions with all five families confirm that they are kept informed following GP visits if the status of their family member changes or immediately following any adverse event. Six of six residents state that they are kept informed and engaged.There is an interpreter policy and staff are able to access interpreting services if required. There are no residents currently requiring interpreting services. |
| Standard 1.2.1: GovernanceThe governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers. | FA | Marvon Downs is a 31 bed rest home facility. There were 30 residents living at the facility during the audit. It is managed by a manager/owner, and a clinical nurse manager. The business philosophy and mission statement are documented in the business plan. This information is shared with residents and families in the resident information pack. There is evidence that the business plan is regularly reviewed by the manager/owner. Strategic goals are documented and are regularly reviewed in the manager meetings. Each goal includes an aim and action plan and is signed off by the manager/owner when completed. The manager/owner has owned the facility for 10 years. His previous experience includes work in the hospitality industry. He is supported by a full-time clinical nurse manager who is a registered nurse (RN). She has over twenty-eight years of aged care experience. They each attend more than eight hours of professional development annually relating to the management of a rest home environment.This provisional audit was undertaken to establish the preparedness of the prospective provider and establish the level of conformity of the existing provider’s service under offer. The prospective owners have experience in managing an aged care facility and also own and manage another aged care facility. A transitional plan has been developed around change of ownership and management. The prospective owner reported the current policies, systems and staff (except management) will remain in place following the purchase. A new facility manager (experienced aged care registered nurse) will commence at Marvon Downs. The management team of Ambridge Rose Manor Limited will oversee all operational aspects of Ambridge Rose Villa Ltd t/a Marvon Downs Rest Home and provide support to the facility manager.The newly appointed acting manager (RN) has a Post Grad Diploma in Leadership in a Residential Care Facility. The prospective owner stated that the current owner, clinical manager and office manager will be replaced by new Acting Facility Manager with support from Ambridge Rose Manor Ltd. |
| Standard 1.2.2: Service Management The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.  | FA | The manager/owner is supported by a full-time (Monday – Thursday) clinical manager who holds a current practising certificate as a registered nurse (RN). A part-time registered staff RN works every Saturday and alternate Sundays. She also provides registered nursing cover in the absence of the clinical nurse manager. An RN is scheduled on-call when an RN is not on site. Administrative duties are undertaken by an administrative manager. She is responsible for the health and safety programme, and education and training schedules. She assumes additional administrative responsibilities in the manager/owner’s absence. With change of ownership the prospective owner stated the management team from Ambridge Rose Manor will provide oversight to the facility manager. This includes the owner/CEO who will oversee all operations and management of Ambridge Rose Manor Ltd and Ambridge Rose Villa Ltd. The owner/manager of Ambridge Rose Manor will oversee all consumer contact and provide support to the facility manager. The general manager at Ambridge Rose Manor Ltd will provide human resources support to the facility manager and financial management of Ambridge Rose Villa Ltd. The clinical manager at Ambridge Rose Manor will provide clinical support to the facility manager. The Quality Manager/EN at Ambridge Rose Manor will oversee and provide support on quality, internal auditing and training issues to the facility manager. In absence of the facility manager, the owner/CEO of Ambridge Rose Manor will provide management oversight with clinical support by the clinical manager from Ambridge Rose Manor.  |
| Standard 1.2.3: Quality And Risk Management SystemsThe organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles. | FA | Marvon Downs has a quality and risk management programme in place. Interviews with the manager/owner, the clinical nurse manager, an administrative manager, three healthcare assistants, a chef, an activities coordinator, housekeeping staff and a review of management and staff meeting minutes reflects their understanding of the quality and risk management system.The service has policies and procedures and associated implementation systems to provide a good level of assurance that it is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. The policies are reviewed two-yearly with staff informed of any changes through the monthly staff meetings (evidenced in the staff meeting minutes as a regular agenda item). The footer section of each policy provides evidence of policies that have been reviewed and policies that have been either added or updated. The service was previously using policies and procedures developed by a consultant. They are now using policies and procedures developed by another consultant. These policies and procedures have been personalised for Marvon Downs.There is the monthly collation of accident/incident data and monthly surveillance of infection reports. An annual internal audit schedule was sighted for the service with evidence of internal audits occurring as per the audit schedule. Corrective actions are implemented where opportunities for improvements are identified. Quality initiatives over the past year have included becoming a smoke-free environment, implementing an on-line education and training programme for staff (to complement the current in-service programme), increasing the number of activities staff, which is being led by a qualified diversional therapist, and implementing ‘Spark of Life’ initiatives for the residents who are suffering from dementia. Quality and risk data including complaints, incidents/accidents, audits, and corrective action plans are discussed in each monthly manager’s meeting and staff meeting. A risk management plan is in place. The service has a health and safety system in place. A health and safety officer is identified for the service. Health and safety audits take place each quarter. Hazard identification forms and a hazard register are in place. The prospective owner stated that initially there is no intended change to the quality management system. However there is a six month plan to transition from a paper based system to an electronic records system using programmes which are currently used at Ambridge Rose Manor Ltd. The entire system will be reviewed as part of the first 90 days. |
| Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.  | FA | D19.3b; There is an incident reporting policy that includes definitions, and outlines responsibilities including immediate action, reporting, monitoring, corrective actions to minimise and debriefing. The service collects incident and accident data. Individual incident reports are completed for each incident/accident with immediate action noted and any follow up action required. The data is linked to the service’s quality and risk management programme. Fifteen incident/accident forms were reviewed across the service and all demonstrated follow up by an RN. Non-clinical events may be followed up by the health and safety officer or the manager/owner. The manager/owner and clinical nurse manager are aware of their statutory reporting obligations. There have been no serious events that have been required to be reported to specific authorities.  |
| Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.  | PA Low | Annual practising certificates were sighted for the clinical nurse manager, staff registered nurse, general practitioner, podiatrist and pharmacy services. Six staff files were randomly selected for review (four healthcare assistants, one clinical nurse manager, and one diversional therapist). There are recruitment policies in place including referee and police checks. Copies of interviews are kept on file. There is evidence of signed employment agreements and signed job descriptions that are held in the staff files. All staff underwent a comprehensive orientation programme that included observations and sign-off by a senior staff member when competency is achieved. Completed orientation checklists were sighted in all six staff files.D17.7d: There are implemented competencies for staff that include medication, infection control and code of rights. The administrative manager is responsible for coordinating the education and training programme for staff. She invites external speakers and ensures that content and attendance records are retained. Over eight hours of education are provided for staff each year. This includes in-service education and training and online learning modules provided by an external aged care education consultant. Missing in the education and training programme is teaching chemical safety for staff who are involved in handling chemicals. This is a required improvement.Professional development for the nursing staff is supported by CMDHB, East Health Trust Primary Health Organisation (PHO) and the New Zealand Nursing Council. The clinical manager has attended training on InterRAI care plans.With the change in ownership, the training programme will be managed by the facility manager with support from the Quality Manager/EN at Ambridge Rose Manor. |
| Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers. | FA | There is a rostering framework that aligns with contractual requirements and includes skill mix requirements and demand fluctuations. The clinical nurse manager is a registered nurse who is on site nine hours a day, Monday – Thursday. She is assisted by a registered nurse who works the AM shift every Saturday and on alternate Sundays. An RN is on-call when an RN is not on duty. There are two healthcare assistants on the AM shift (7am – 3pm), two healthcare assistants on the PM shift (3pm-11pm) and two healthcare assistants on duty during the night shift (duty rosters sighted). There are separate cleaning and laundry staff.The manager/owner is onsite approximately 48 hours per week and is on call 24 hours a day, seven days a week. A diversional therapist leads the activities programme. Three activities staff work 25 hours per week.Resident acuity is linked to the number of staff available.Residents (six of six) and relatives (five of five) report staff are available to meet their needs.Interview with the prospective owner stated that other than change to the management team staffing and rosters will remain the same. The appointed acting manager is an experienced aged care manager. She will be supported by a part time registered nurse or full time enrolled nurse (additional to the current weekend RN). |
| Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. | FA | The residents’ files are appropriate to the service type. Residents entering the service have the relevant initial information recorded within 24 hours of entry into the service. Policies are in place relating to patient information. These policies are linked to the Health Information Privacy Code 1994 and the Privacy Act 1993. Individual residents’ files demonstrate service integration. All six residents’ files sighted are sufficiently detailed. Residents’ files are dated and timed. Entries take place every two – five days with exception reporting for all unique events pertaining to the resident. The name and designation of staff is noted for entries in the records sampled. Current and archived records are stored securely. The records can only be removed by authorised personal. Information containing personal resident information is kept confidential and cannot be viewed by other residents or members of the public. |
| Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified. | FA | Prior to entry potential residents, have a needs assessment completed by the relevant needs assessment and co-ordination service (sighted in six files reviewed). The service has an admission policy, admission agreement and a resident information pack available for residents/families at entry. The information pack includes all relevant aspects of service and residents and/or family are provided with associated information such as the Health and Disability Services Code of Rights, how to access advocacy and the complaints process.D13.3: The admission agreement reviewed aligns with a) -k) of the ARC contract.D14.1: Exclusions from the service are included in the admission agreement.D14.2: The information provided at entry includes examples of how services can be accessed that are not included in the agreement |
| Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.  | FA | There are polices to describe guidelines for death, discharge, transfer, documentation and follow up. There is an associated form for staff to complete. A record is kept and a copy of details is kept on the resident’s file. All relevant information is documented and communicated to the receiving health provider or service. A transfer form accompanies residents to receiving facilities.  |
| Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines. | PA Low | Medication policies align with accepted guidelines. Controlled drugs are stored appropriately. The controlled drug register is completed appropriately. The service uses the two weekly robotic medication management system. Medication charts have photo IDs. There is a signed agreement with the pharmacy. Medications are checked on arrival by the clinical nurse manager and any pharmacy errors recorded and fed back to the supplying pharmacy. There are no residents self- administrating medications. Staff sign for the administration of medications on a medication signing sheet. All 12 administration sheets sampled correlate with prescribed instructions. All 12 medication charts have indication for use of PRNs. The medication folder includes a list of specimen signatures. Medication profiles are legible, up to date and reviewed at least three monthly by the GP. The medication chart has alert stickers for; a) controlled drugs, b) allergies and c) duplicate name. Medication competencies are current for those staff administering medications – clinical nurse manager, registered nurse (weekend) and senior healthcare assistants. The clinical nurse manager was observed administrating medications on the day of the audit and correct procedures were carried out including checking the GP prescribed medication chart and signing for administration after the medication was taken. There is one instance of a verbal order that is not signed by a doctor and warfarin prescribing requires review, these are areas requiring improvement.D16.5.e.i.2; Medication charts reviewed identified that the GP had seen and reviewed the resident three monthly and the medication chart was signed.  |
| Standard 1.3.13: Nutrition, Safe Food, And Fluid ManagementA consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.  | FA | Marvon Downs rest home cooks all food on site. There is one chef who works 35 hours/week (Monday through Friday), and a weekend cook who works 14 hours across Saturday and Sunday. The chef interviewed has been in the role five years. All staff have completed relevant food safety training. There is a three weekly rotating menu. The summer menu is being reviewed by a dietician at the time of audit (email correspondence sighted).A food services manual is available that ensures that all stages of food delivery to the resident are documented and comply with standards, legislation and guidelines. This includes policy, food and nutrition guidelines for the older person, sample menus, food services and staff responsibilities. The food is prepared in the main kitchen and served directly to residents in the dining room. There is one large fridge and one freezer. All fridges and freezers temperatures are recorded daily on the recording sheet sighted. Food temperatures are recorded daily. The chef prepares the evening meal for the residents and kitchen hands serve to the residents in the evening. All food in the freezer and fridge is labelled or dated and stored correctly. Decanted food in containers is dated.The residents have a diet profile developed on admission, which identifies dietary requirements and likes and dislikes. Changes to residents’ dietary needs are communicated to the kitchen as reported by the chef interviewed. Special diets are noted in the kitchen. Weights are recorded monthly. Residents report satisfaction with food choices, meals are well presented. Lunchtime meals were observed being served and were attractively presented and temperature of food recorded prior to meals being served. Alternative meals are offered as required and individual resident likes and dislikes are noted in the kitchen. There is evidence that there are additional snacks available over 24 hours including sandwiches, biscuits, and crackers. |
| 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 admission policy describes the declined entry to services process. Marvon Downs rest home records the reason for declining entry to residents should this occur and communicates this to residents/family and refers the resident/family back to the referral agency. The clinical nurse manager reports the only residents declined entry are those requiring a higher level of care. |
| Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | The initial nursing assessment is completed within 24 hours of admission and the care plan is completed within three weeks in the six files reviewed. Personal needs information is gathered during admission including cultural and spiritual needs and likes and dislikes. Assessments are conducted in an appropriate and private manner. Assessments and care plans are detailed and include input from a general practitioner and medical specialists as appropriate. Assessment tools such as pressure area risk, falls risk, pain, continence and nutritional assessments are completed on admission. The clinical nurse manager has been trained in the use of InterRAI and is starting the InterRAI assessment process. Five family and six residents interviewed are very satisfied with the support provide |
| Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | The six files reviewed: a resident who had been assessed as requiring dementia level care and reassessed as rest home (tracer), a frequent faller, a resident on warfarin, a young person, a resident with an ulcer following removal of carcinoma, and a new admission.Long term and short term care plans are evident in five of six files reviewed. One resident was a new admission, and the initial assessment and care plan are completed, with the long term care plan being in process at the time of audit. The care plans include interventions relating to identified areas of need and reflect variances in resident health status. There is evidence of six monthly review in five (of six) files sampled which is signed by either the clinical nurse manager or the registered nurse. One resident had not been in the service six months. The care plan is completed within three weeks of admission by the clinical nurse manager or registered nurse. The resident and family are seen to have been involved in the care planning process in the six files reviewed. D16.3f: Residents and relatives interviewed confirm care delivery and support by staff is consistent with their expectations. D16.3k: Short term care plans are in use for changes in health status. |
| Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | Six resident files were reviewed. All identified an initial nursing assessment and care plan was completed within 24 hours and in five files the long term care plan was completed within three weeks. One resident’s long term care plan was in the process of being completed. There is documented evidence the care plans are reviewed by the clinical nurse manager or the registered nurse and amended when current health changes. Five care plans evidence evaluations completed at least six monthly, one resident has not been in the service six months. Activity assessments and the activities care plans have been completed by the diversional therapist. The care being provided is consistent with the needs of residents. This is evidenced by discussions with residents, families, healthcare assistants, and clinical nurse manager. A review of short term care plans, long term care plans, evaluations and progress notes demonstrates integration. There is evidence of three monthly medical review of the residents by the GP. Care delivery is recorded by healthcare assistants or the registered nurse/clinical nurse manager in the progress notes. Progress notes are completed at intervals of not more than four days dependent on the residents health status. When a resident's condition alters, the clinical nurse manager arranges a GP visit or a specialist referral as required. The three healthcare assistants and clinical nurse manager interviewed state they have the equipment referred to in care plans and necessary to provide care. Staff report there are always adequate supplies (sighted). Six residents and five family interviewed were complimentary of care received at the facility.D18.3 and 4 Dressing supplies are available. A short term care plan is in place for wounds that are being treated The wounds were reviewed within the stated timeframe and include GP involvement for antibiotics and on-going dressings. The clinical nurse manager could describe the referral process for accessing specialists such as wound and mental health services for older people. Continence products are available and continence assessment is seen in files reviewed. Continence products used are identified in long term care plans. Continence management in-service training was provided in 2013. During the tour of facility it was observed that all staff treated residents with respect and dignity, knocked on doors before entering residents’ rooms and ensured residents’ dignity and privacy was protected when transferring residents to the shower or toilet. Residents interviewed were able to confirm that privacy and dignity was maintained |
| Standard 1.3.7: Planned ActivitiesWhere specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service. | FA | There are three activities staff including a diversional therapist (DT) at Marvon Downs. They work a total of 25 hours across Monday to Friday. As the DT was on leave during the audit, an activity coordinator was interviewed. The DT is responsible for developing the activities programme (interview with activities coordinator), and a seven day programme was reviewed. The healthcare assistants are responsible for implementing the activities programme during the weekend. The activities coordinator (interviewed) attended the DT conference and there is interest in implementing the ‘spark of life’ at Marvon Downs. The programme is developed monthly and a copy of the programme is available on the notice board. Activities are provided in the lounge, dining room, gardens (when weather permits) and one on one input in resident’s rooms when required. Residents are also involved in activities outside of the facility such as the stroke club. The service arranges a monthly bus outing which 13-14 residents can go on. On the day of audit residents were observed being actively involved with a variety of activities. Residents attend church services on site and in the community. Participation in all activities is voluntary. Residents have an initial assessment completed over the first few weeks after admission obtaining a complete social history of past and present interests and life events and information from this is added into the activities care plan. This is reviewed six monthly. An attendance record is kept of individual resident’s activities and progress notes completed. The resident/family/EPOA as appropriate is involved in the development of the activity plan All activity staff have a current first aid certificate. |
| Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | There is at least a three monthly review for residents by the medical practitioner. D16.4a Care plans are reviewed and evaluated by the clinical nurse manager (or registered nurse) six monthly or when changes to care occur as sighted in all six care plans sampled. There are short term care plans (STCP) to focus on acute and short-term issues. STCPs reviewed evidence evaluation and are signed and dated by the clinical nurse manager when issues have been resolved. Staff are informed of any changes to resident need at handover between shifts. Examples of STCP's in use included infections and wounds. Healthcare assistants (three) confirm they are updated to any changes to/or in resident’s care or treatment during handover sessions which occur at the beginning of each shift and this was observed during the audit.ARC D16.3c: All initial nursing assessment/care plans were evaluated by an RN within three weeks of admission. |
| 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.  | FA | The clinical nurse manager described the referral process to other medical and non-medical services. Referral documentation is maintained on resident files. Examples of referrals sighted were to NASC services and respiratory nurse specialist.D16.4c: The service provided examples of where a resident’s condition had changed and the resident was reassessed for a higher level of care.D 20.1; Discussions with the clinical nurse manager identified the service has access to wound care nurse specialists, incontinence specialists, gerontology specialist, podiatrist and physiotherapist. |
| Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery. | FA | There are policies in place for waste management, waste disposal for general waste and medical waste management. There are approved sharps containers for the safe disposal of sharps. All chemicals are labelled with manufacturer labels. There are designated areas for storage of cleaning/laundry chemicals within the facility, with larger quantities being stored outside in a locked shed. Product use charts are available. Hazard register identifies hazardous substance. Gloves, aprons, and goggles are available for staff. Interview with three caregivers and the house keeper described management of waste and chemicals.  |
| Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose. | FA | The service displays a current building warrant of fitness dated 10 March 2014. Hot water temperatures checks are conducted and recorded monthly and recordings reviewed year to date 2014 are recorded below 45 degrees Celsius. Medical equipment is calibrated annually. A monthly inspection includes testing of emergency lighting, fire alarms, hose reels. The interior is well maintained with a home-like décor and furnishings. There are two separate dining areas and three lounge rooms. There are six communal toilets and three communal shower facilities. Two rooms have ensuites and one room with an ensuite toilet. Residents were observed to safely mobilise throughout the facility. There is easy access to the outdoors. The exterior is well maintained outdoor shaded seating, lawn and gardens. Interviews with three caregivers confirm there was adequate equipment to carry out the cares according to the resident needs as identified in the care plans. The prospective owner stated there are no planned changes identified for the environment at this stage. |
| Standard 1.4.3: Toilet, Shower, And Bathing FacilitiesConsumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements. | FA | There are two rooms with ensuites and one room with an ensuite toilet. There are six communal toilets and three communal shower facilities – note comment against 1.1.3 re shower door. Facilities were viewed to be kept in a clean and in a hygienic state. Regular audits are completed and included in the quality programme. Six residents interviewed state their privacy and dignity is maintained while attending to their personal cares and hygiene. Hand washing and drying facilities are adjacent to the toilet. Liquid soap and paper towels are available in all toilets. Fixtures, fittings and floor and wall surfaces are made of accepted materials to support good hygiene practices for this environment. The communal toilets and showers are well signed and identifiable and include large vacant/engaged signs. |
| Standard 1.4.4: Personal Space/Bed Areas Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.  | FA | All rooms are spacious enough to meet the assessed resident needs. Residents are able to manoeuvre mobility aids around the bed and personal space. Healthcare assistants interviewed report that rooms have sufficient room to allow cares to take place. The bedrooms are personalised. There are two separate dining areas and three lounge rooms. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and all six residents interviewed report they can move around the facility and staff assist them if required. |
| Standard 1.4.5: Communal Areas For Entertainment, Recreation, And DiningConsumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs. | FA | There are two separate dining areas and three lounge rooms. The dining rooms are located close to the kitchen area. All areas are easily accessible for the residents. The furnishings and seating are appropriate for the consumer group. Residents were seen to be moving freely both with and without assistance throughout the audit and all six residents interviewed report they can move around the facility and staff assist them if required. |
| Standard 1.4.6: Cleaning And Laundry ServicesConsumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided. | FA | All laundry is completed on site. Chemicals are stored in a locked room and also in a locked shed outside the facility. The house keeper has the key on her person. All chemicals are labelled with manufacturer’s labels. Residents and relatives expressed satisfaction with cleaning and laundry services. On a tour of the facility the carpets were noted to be clean. All bedrooms, hallways and communal areas were clean and tidy in appearance. There is dedicated laundry staff.  |
| Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations. | FA | Emergency and disaster policies and procedures are in place. An approved fire evacuation plan is in place. Fire evacuation drills take place every six months. The orientation programme and annual education and training programme include mandatory fire and security training. Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit and all equipment has been checked within required timeframes. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets and gas cooking. A back up three- hour battery for emergency lighting is in place. A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity. Six of six residents report that staff respond to call bells in a timely manner. Staff hold current first aid/CPR training certificates. There is a minimum of one person with a current first aid/CPR certificate available 24 hours a day, seven days a week. External lighting is adequate for safety and security.  |
| Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature. | FA | All communal and resident bedrooms have external windows with plenty of natural sunlight. General living areas and resident rooms are appropriately heated and ventilated. Electric heaters are used to heat rooms. Six residents and one family interviewed state the environment is warm and comfortable. During the audit the facility was a comfortable temperature. |
| Standard 3.1: Infection control managementThere 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.  | FA | The infection control programme and its content and detail, is appropriate for the size, complexity, and degree of risk associated with the service. There is a job description for the infection control coordinator who is the clinical nurse manager (RN). There is an implemented infection control programme that is linked into the quality management system. The infection control programme is reviewed annually. The facility has access to GPs, local laboratory, and the infection control and public health departments at the local DHB for advice.  |
| Standard 3.2: Implementing the infection control programmeThere are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | Infection control matters are discussed at the management and (monthly) staff meetings which include a cross section of staff. The facility also has access to an infection control nurse specialist, public health and GPs. |
| Standard 3.3: Policies and proceduresDocumented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided. | FA | D 19.2a: The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team, training and education of staff. Infection control procedures developed in respect of the kitchen, laundry and housekeeping incorporate the principles of infection control. These principles are documented in the service policies. External expertise can be accessed as required, to assist in the development of policies and procedures.  |
| Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers. | FA | The infection control (IC) coordinator is responsible for coordinating/ providing education and training to staff. The IC coordinator has completed appropriate IC training including attendance at an infection prevention and control study day in May 2014. The orientation package includes specific training around hand washing. The IC coordinator provides training both at orientation and on-going. Training on infection control is included in as part of the biannual training schedule – Care-on-line modules completed March and April 2014, and an external speaker is scheduled for October. Resident education is expected to occur as part of providing daily cares.  |
| Standard 3.5: SurveillanceSurveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | There is a policy describing surveillance methodology for monitoring of infections. The infection control coordinator collates information obtained through surveillance to determine infection control activities and education needs in the facility. Individual infection report forms are completed for all infections. Definitions of infections are in place appropriate to the complexity of service provided. Infection control data is collated monthly and reported at both the management and staff meetings. The surveillance of infection data assists in evaluating compliance with infection control practices. The infection control programme is linked with the quality programme. There is close liaison with the GPs who advise and provide feedback /information to the service. Systems in place are appropriate to the size and complexity of the facility. The service report having had a norovirus outbreak at the beginning of year with relevant notifications having been made. |
| Standard 2.1.1: Restraint minimisationServices demonstrate that the use of restraint is actively minimised.  | PA Low | The restraint minimisation policy aims to ensure the safety of residents, service providers and others through minimising preventable and avoidable risks throughout restraint. These procedures include assessment of least restrictive option, consent, monitoring and evaluation. The clinical nurse manager is the restraint coordinator. Education is provided to staff around restraint, de-escalation and challenging behaviours. The service currently has no clients using restraint or enablers although environmental restraint is in place via key pad entry at the outside gate.  |

# 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.

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| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.5A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers. | PA Low | The administrative manager is responsible for coordinating the education and training programme for staff. She invites external speakers and ensures that content and attendance records are retained. Over eight hours of education are provided for staff each year. This includes in-service education and training and online learning modules provided by an external aged care education consultant. Missing in the education and training programme is teaching chemical safety for staff who are involved in handling chemicals.  | Staff who are involved in handling chemicals have not had chemical safety training. | Ensure staff who handle chemicals received training on chemical safety.90 days |
| Criterion 1.3.12.1A 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. | PA Low | All medications are kept in a locked trolley in the treatment room. The medication fridge temperature is recorded daily. Twelve resident medication charts sampled are identified with photographs and allergy status. The prescribing of regular and PRN medications meets legislative requirements.  | On review of 12 medication charts the following was noted: a) one resident is prescribed warfarin and the prescription reads: Marevan 1mg as per INR. The general practice phones the facility following monthly INR and informs the dose, this is written on a monitoring form and administered by staff. There is no prescription signed by the general practitioner. It is noted this was being addressed during the audit. b) one medication chart (2012 entry) had a verbal order recorded taken by a registered nurse from a consultant psychiatrist that has not been signed by a medical practitioner.  | Ensure charting and administration of medication aligns with best practice.60 days |
| Criterion 2.1.1.4The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety. | PA Low | The restraint minimisation policy aims to ensure the safety of residents, service providers, and others through minimising preventable and avoidable risks throughout restraint. These procedures include assessment of least restrictive option, consent, monitoring and evaluation. The clinical nurse manager is the restraint coordinator. Education is provided to staff around restraint, de-escalation and challenging behaviours. The service currently has no clients using restraint or enablers although environmental restraint is in place via key pad entry at the outside gate.  | Environmental restraint is in place, limiting the freedom of movement for a select group of residents with dementia. | Ensure restraint processes are implemented for those residents whose freedom of movement is restricted.90 days |

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

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

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

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

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End of the report.