

Golden Concept E Limited - Eversleigh Hospital

Introduction

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

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

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

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

The specifics of this audit included:

Legal entity:	Golden Concept E Limited	
Premises audited:	Eversleigh Hospital	
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)	
Dates of audit:	Start date: 22 February 2016	End date: 23 February 2016
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:	34	

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

Eversleigh Hospital is owned and operated by Golden E Concepts Limited. The service provides care for up to 36 residents requiring hospital and rest home level care. On the day of the audit, there were 34 residents. The service is overseen by a facility manager, who is a registered nurse and well qualified and experienced for the role and is supported by the senior registered nurse. Residents spoke positively about the service provided.

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

This audit has identified improvements required around quality and risk management systems, human resource management, education, entry to service, assessment, and restraint minimisation and safe practice.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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Staff at Eversleigh Hospital strive to ensure that care is provided in a way that focuses on the individual, values residents' autonomy and maintains their privacy and choice. The service functions in a way that complies with the Health and Disability Commissioner's Code of Consumers' Rights. Cultural needs of residents are met. Policies are implemented to support residents' rights, communication and complaints management. Information on informed consent is included in the admission agreement and discussed with residents and relatives. Care plans accommodate the choices of residents and/or their family/whānau. Complaints and concerns have been managed and a complaints register is maintained.

Organisational management

<p>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.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The quality and risk management programme includes service philosophy, goals and a quality planner. Meetings are held to discuss quality and risk management processes. Resident/family meetings have been held and residents and families are surveyed regularly. Health and safety policies, systems and processes are implemented to manage risk. Incidents and accidents are reported. A comprehensive education and training programme has been documented. Appropriate employment processes are adhered to. A roster provides sufficient and appropriate coverage for the effective delivery of care and support.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Some standards applicable to this service partially attained and of low risk.
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Entry to the service is managed by the facility manager. There is comprehensive service information available. The registered nurses complete initial assessments. The registered nurses complete care plans and evaluations. Care plans are written in a way that enables all staff to clearly follow their instructions. Residents and family interviewed confirmed they were involved in the care planning and review process. Each resident has access to an individual and group activities programme. Medication is stored appropriately in line with legislation and guidelines. Staff have had education around medication management. General practitioners review residents at least three monthly or more frequently if needed. Meals are prepared on site. The menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are able to be provided.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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The building has a current warrant of fitness and emergency evacuation plan. Ongoing maintenance issues are addressed. Chemicals are stored safely throughout the facility. Appropriate policies are available along with product safety charts. Most bedrooms are single occupancy with shared toilets and showers. Toilet/shower facilities are constructed for ease of cleaning. Laundry is completed on site by care staff. There is sufficient space to allow the movement of residents around the facility using mobility aids. There are two lounge and dining areas, one for each wing and a communal activity area. The internal areas are able

to be ventilated and heated. The outdoor areas are safe and easily accessible. Cleaning and maintenance staff are providing appropriate services. Staff have planned and implemented strategies for emergency management. Emergency systems are in place in the event of a fire or external disaster.

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.		Some standards applicable to this service partially attained and of low risk.
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Eversleigh has restraint minimisation and safe practice policies in place. On the day of audit, there were six residents with restraint and four residents with an enabler.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.		Standards applicable to this service fully attained.
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Infection control management systems are in place to minimise the risk of infection to consumers, service providers and visitors. The infection control programme is implemented and meets the needs of the organisation and provides information and resources to inform the service providers. The type of surveillance undertaken is appropriate to the size and complexity of the organisation.

Standardised definitions are used for the identification and classification of infection events. Results of surveillance are acted upon, evaluated and reported to relevant personnel in a timely manner.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	41	0	8	1	0	0
Criteria	0	87	0	13	1	0	0

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

Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>The Health and Disability Commissioner Code of Health and Disability Services Consumers' Rights (the Code) policy and procedure is implemented. Discussions with staff (six caregivers, two registered nurses (RN), one activities coordinator, and one facility manager) confirm their familiarity with the Code. Interviews with six residents (three rest home and three hospital) and four families (two rest home and two hospital) confirm the services being provided are in line with the Code. The Code is discussed at resident and staff/quality meetings.</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>Informed consent processes are discussed with residents and families on admission (Link 2.1.1.4). The resident or their EPOA signs written consents. Six resident files sampled (three hospital and three rest home) demonstrated that advanced directives are signed for separately. There is evidence of discussion with family when the GP has completed a clinically indicated not for resuscitation order. Caregivers and registered nurses interviewed confirmed verbal consent is obtained when delivering care. Family members are involved in decisions that affect their relatives' lives. All six resident files sampled had an admission agreement signed on or before the day of admission and consents.</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>A policy describes access to advocacy services. Staff have not received training on advocacy in past two years (Link1.2.7.5). Information about accessing advocacy services information is available in the entrance foyer. This includes advocacy contact details. The information pack provided to residents at the time of entry to the service provides residents and family/whānau with advocacy information. Advocate support is available if requested. Interview with staff and residents informed they are aware of advocacy and how to access an advocate.</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>Residents are encouraged to be involved in community activities and maintain family and friends networks. On interview, all staff stated that residents are encouraged to build and maintain relationships. All residents interviewed confirmed that relative/family visiting could occur at any time.</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 has a complaints policy that describes the management of complaints process. There is a complaints form available. Information about complaints is provided on admission. Interview with residents demonstrated an understanding of the complaints process. All staff interviewed were able to describe the process around reporting complaints.</p> <p>There is a complaints register. Verbal and written complaints are documented. There have been eleven complaints since May 2015 and all complaint documentation was reviewed. All eleven complaints had noted investigation, timeframes, corrective actions when required and resolutions were in place if required. Results are fed back to complainants. Discussions with residents confirmed that any issues are addressed and they feel comfortable to bring up any concerns.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>There are posters of the code of rights on display throughout the facility and leaflets are available in the foyer of the facility. The service is able to provide information in different languages and/or in large print if requested. Information is also given to next of kin or enduring power of attorney (EPOA) to read with the resident and discuss. On entry to the service, the facility manager discusses the information pack with the resident and the family/whānau. The information pack includes a copy of the Code of Rights.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And</p>	FA	<p>The service has policies, which align with the requirements of the Privacy Act and Health Information Privacy Code. Staff were observed respecting resident's privacy and could describe how they manage</p>

<p>Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>		<p>maintaining privacy and respect of personal property. All residents interviewed stated their needs were met.</p> <p>A policy describes spiritual care. Clergy visit the service weekly and are available to meet the residents spiritual care needs at other times. All residents interviewed indicated that resident's spiritual needs are being met when required.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	FA	<p>The service has established cultural policies to help meet the cultural needs of its residents. There is a Māori health plan. On the day of the audit, no residents identified as Māori.</p> <p>Cultural and spiritual practice is supported and identified needs are incorporated into the care planning process and review. Discussions with staff confirm that they are aware of the need to respond to cultural differences.</p>
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>The service has established cultural policies aimed at helping to meet the cultural needs of its residents. All residents interviewed reported that they were satisfied that their cultural and individual values were being met. Information gathered during assessment including residents cultural beliefs and values, is used to develop a care plan, which the resident (if appropriate) and/or their family/whānau are asked to consult on. Staff have not received training on cultural awareness in the past 2 years (Link 1.2.7.5).</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>The facility has a staff code of conduct which states there will be zero tolerance against any discrimination occurring. The RNs supervise staff to ensure professional practice is maintained in the service. The abuse and neglect processes cover harassment and exploitation. All residents interviewed reported that the staff respected them. Job descriptions include responsibilities of the position, ethics, advocacy and legal issues. The orientation and employee agreement provided to staff on induction includes standards of conduct.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service has policies to guide practice that aligns with the health and disability services standards, for residents with aged care and residential disability needs. Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training. The resident satisfaction survey completed in October 2015 reflects high levels of satisfaction with the services provided. Residents</p>

		<p>interviewed spoke very positively about the care and support provided. Staff interviewed had a sound understanding of principles of aged care and stated that they feel supported by the management team.</p> <p>Staffing policies include pre-employment and the requirement to attend orientation and ongoing in-service training (Link 1.2.7.5).</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>Residents interviewed stated they were welcomed on entry and given time and explanation about the services and procedures. Accident/incidents, complaints procedures and the policy and process around open disclosure alerts staff to their responsibility to notify family/next of kin of any accident/incident and ensure full and frank open disclosure occurs. Ten incidents/accidents forms were reviewed. The forms included a section to record family notification. All ten forms indicated family were informed or if family did not wish to be informed. Relatives interviewed confirmed that they are notified of any changes in their family member's health status.</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>Eversleigh is owned and operated by Golden Concepts E Limited. Golden Concepts E Limited purchased the service in May 2015. The service provides rest home and hospital level care for up to 36 residents, which includes two residents receiving rest home care in the village apartments.</p> <p>On the day of the audit, there were nine rest home level (including two residents receiving rest home care in the village apartments) and 25 hospital level residents. All residents were covered by the Aged Related Residential Care contract. Five rooms in the rest home/hospital facility are identified as dual-purpose.</p> <p>The facility manager is a registered nurse and maintains an annual practicing certificate. She has been in a management role at the facility for three years and continued as the facility manager when Golden Concepts E Limited purchased the service. The facility manager reports weekly to a director on a variety of operational issues. Golden Concepts E Limited has an overall business/strategic plan and Eversleigh has a facility quality and risk management programme in place for the current year. The organisation has a philosophy of care, which includes a mission statement. The facility manager has completed in excess of eight hours of professional development in the past 12 months.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the</p>	FA	<p>In the absence of the facility manager, the senior registered nurse is in charge with support from the director, the registered nurses and care staff.</p>

service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Golden Concepts E Limited has an overall business/strategic plan and Eversleigh has a facility quality and risk management programme in place for the current year. The quality and risk management plan monitors all contractual and standards compliance.</p> <p>Data is collected in relation to a variety of quality activities and an internal audit schedule has been developed. Internal audits are completed but not as documented in the audit schedule. Interviews with staff confirmed that quality data is discussed at monthly staff meetings to which all staff are invited. Restraint and enabler use is reported within the quality and clinical staff meetings.</p> <p>Corrective actions are documented where internal audits identify opportunities for improvements, however corrective action plans are not always specific. The service has a health and safety management system. There are implemented risk management, and health and safety policies and procedures in place including accident and hazard management. The service policies are required to be reviewed at least every two years. Staff have access to manuals.</p> <p>Residents are surveyed to gather feedback on the service provided and the outcomes are communicated to residents, staff and families. Resident/relative meetings are held quarterly.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	PA Low	<p>There is an accidents and incidents reporting policy. The facility manager investigates accidents and near misses and analysis of incident trends occurs. There is a discussion of incidents/accidents at monthly quality meetings. A registered nurse conducts clinical follow-up of residents. Ten incident forms sampled (from a sample of resident files) did not always demonstrate that appropriate clinical follow-up and investigation occurred following incidents. The service was unaware of the requirement to notify relevant authorities in relation to all essential notifications.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management</p>	PA Moderate	<p>There are human resource management policies in place. This includes that the recruitment and staff selection process requires that relevant checks be completed to validate the individual's qualifications, experience and veracity. A copy of practising certificates is kept. Seven staff files were reviewed (one facility manager, one registered nurse, two caregivers, one activities coordinator, one cook, one</p>

<p>processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>		<p>housekeeper) and evidence that reference checks were completed before employment is offered. Not all new staff had evidence that police vet checks were completed as part of the recruitment process. The service has a comprehensive orientation programme in place that provides new staff with relevant information for safe work practice. New staff did not always complete the orientation programme. The in-service education programme was not fully implemented.</p> <p>The facility manager and registered nurses are able to attend external training, including sessions provided by the local DHB. Two of the five registered nurses have completed InterRAI training. Annual staff appraisals were not evident in all staff files reviewed.</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>Eversleigh policy includes staff rationale and skill mix. Sufficient staff are rostered on to manage the care requirements of the residents. At least one registered nurse is on at any one time. The registered nurse on each shift is aware that extra staff can be called on for increased resident requirements. Interviews with staff, residents and family members identify that staffing is adequate to meet the needs of residents.</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>The resident files are appropriate to the service type. Residents entering the service have all relevant initial information recorded within 24 hours of entry into the resident's individual record. Resident files are protected from unauthorised access by being locked away in the nurses' stations. Informed consent to display photographs is obtained from residents/family/whānau on admission. Other residents or members of the public cannot view sensitive resident information. Entries in records are legible, dated and signed by the relevant healthcare assistant or registered nurse.</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>PA Low</p>	<p>The service has comprehensive admission policies and processes in place. Residents receive an information pack outlining services able to be provided, the admission process and entry to the service. The manager screens all potential residents prior to entry and records all admission enquires. Residents and relatives interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager. The admission agreement in use does not align fully with the requirements of the ARRC contract. The information provided at entry includes examples of how services can be accessed that are not included in the agreement.</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 are policies in place to ensure the discharge of residents occurs safely. Residents who require emergency admissions to hospital are managed appropriately, and relevant information is communicated to the DHB. The service ensures appropriate transfer of information occurs. Relatives interviewed confirmed they were kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	<p>FA</p>	<p>The medication management policies comply with medication legislation and guidelines. Medicines are appropriately stored in accordance with relevant guidelines and legislation. Medication administration practice complies with the medication management policy for the medication rounds sighted. Medication prescribed was signed as administered on the pharmacy generated signing chart. Registered nurses administer medicines. All staff that administer medication have received medication management training and competencies are completed. The facility uses a robotic pack medication management system for the packaging of all tablets. The RN on duty reconciles the delivery and documents this. Twelve medication charts were reviewed (eight hospital and four rest home). All medication charts reviewed evidenced photographs and that allergies were documented. Medical practitioners wrote all medication charts correctly and there was evidence of three monthly reviews by the GP. There were no residents self-medicating on the day of the audit. The facility does not use standing orders.</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>There is a functional kitchen and all food is cooked on site. There is a food services manual in place to guide staff. A resident nutritional profile is developed for each resident on admission, and provided to the kitchen staff. This document is reviewed at least six monthly as part of the care plan review. The kitchen is able to meet the needs of residents who require special diets and the cook works closely with the RN and care staff. The kitchen staff have completed food safety training. The cook stated at interview that the menus are reviewed by a dietitian and documented evidence of this was viewed on the day on the audit. The temperatures of refrigerators, freezers and cooked foods are monitored and recorded daily. There is special equipment available for residents if required. All food is stored appropriately. Residents and the family members interviewed were satisfied with the quality and variety of food served.</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</p>	<p>FA</p>	<p>The service records the reason for declining service entry to residents, should this occur, and communicates this decision to residents/family/whānau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>

and/or their family/whānau is managed by the organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	All appropriate personal needs information is gathered during admission in consultation with the resident and their relative where appropriate. Appropriate assessment tools were completed and assessments were reviewed at least six monthly or when there was a change to a resident's health condition, in files sampled. InterRAI assessments have been implemented (link 1.3.3.3).
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	The long-term care plans reviewed described the support required to meet the resident's goals and needs and identified allied health involvement under a comprehensive range of template headings. Residents and their family/whānau are involved in the care planning and review process. The long-term care plans reviewed have been updated for both long-term and short-term changes in health status. Staff interviewed reported they found the plans easy to follow.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Dressing supplies are available and a treatment room is stocked for use. Continence products are available and residents' files include a urinary continence assessment, bowel management, and continence products identified for day use, night use, and other management. Wound assessments and comprehensive wound management plans were in evidence for seven wounds (two rest home, both BCC and five hospital, three chronic ulcers, one BCC and one PI). Registered nurses (RNs) and caregivers follow the care plan and the RNs report progress against the care plan each shift. If external nursing or allied health advice is required, the RNs will initiate a referral. If external medical advice is required, this will be actioned by the GP. Specialist continence advice is available as needed and this could be described. Short-term care plans were in use for short-term needs and these were evidenced as resolved. Care plan interventions included regular turns, and food and fluid monitoring which caregivers recorded on identified charts.
Standard 1.3.7: Planned Activities Where specified as part of the	FA	The service has an activities coordinator who works part-time over five days. Each resident has an individual activities assessment on admission and from this information an individual activities plan is developed as part of the care plan. Each resident is free to choose whether they wish to participate in the group activities programme or their individual plan. Participation is monitored. There is a five-day

<p>service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>programme provided. One-on-one time occurs on an individual basis for those residents who choose not to participate in the group activities. Residents enjoy activities including fortnightly bus trips, art sessions and entertainers. Local clergy visit those residents who wish them to visit. A residents meeting is held three monthly and copies of the meeting minutes are available for residents. A yearly satisfaction survey is completed where feedback on activities is obtained. All long-term resident files sampled had a recent activities plan within the care plan and this was evaluated at least six monthly when the care plan was evaluated. Residents and families interviewed commented positively on the activity 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>The long-term care plans reviewed were evaluated at least six monthly or earlier if there was a change in health status. The files reviewed evidenced at least a three monthly review by the GP. All changes in health status were documented and followed up. An RN signed care plan reviews. Short-term care plans were evaluated and resolved or were added to the long-term care plan if the problem is ongoing, as sighted in resident files sampled. Where progress is different from expected, the service responds by initiating changes to the care plan.</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>The service facilitates access to other medical and non-medical services. Referral documentation is maintained on resident files. The nurses initiate referrals to nurse specialists and allied health services. Other specialist referrals are made by the GPs. Referrals and options for care were discussed with the family as evidenced in interviews and medical notes. The staff provided examples of where a resident's condition had changed and the resident reassessed.</p>
<p>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.</p>	<p>FA</p>	<p>There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Gloves, aprons, and goggles are available and staff were observed wearing personal protective clothing while carrying out their duties. Infection prevention and control policies state specific tasks and duties for which protective equipment is to be worn. Chemicals sighted were labelled correctly and stored safely throughout the facility. Safety data sheets are available.</p>

<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>The building has a current building warrant of fitness. There is a part time maintenance person employed to address the reactive and planned maintenance programme. All medical and electrical equipment was recently serviced and/or calibrated. Hot water temperatures are monitored and managed below 45 degrees Celsius. The facility has sufficient space for residents to mobilise using mobility aids. The external area is well maintained. Residents have access to safely designed external areas that have shade. Staff stated they had sufficient equipment to safely deliver the cares as outlined in the resident care plans.</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 an adequate number of toilets and shower/bathing areas for residents and separate toilets for staff and visitors. All toilets and shower/bathing areas are shared except for the two residents in the serviced apartments. Toilets and showers have privacy systems in place. Residents interviewed confirmed their privacy is assured when staff are undertaking personal cares.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>All residents rooms are of an appropriate size to allow care to be provided and for the safe use and manoeuvring of mobility aids. Residents are encouraged to personalise their bedrooms.</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>	<p>FA</p>	<p>The communal areas include two lounge/dining areas, one activity area and the foyer where seating is available for the residents and visitors. The communal areas are easily and safely accessible for residents.</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>	<p>FA</p>	<p>Dedicated cleaning staff clean the facility. They have access to a range of chemicals, cleaning equipment and protective clothing. Residents and relatives interviewed were satisfied with the standard of cleanliness in the facility.</p> <p>All laundry is carried out on site. Residents and relatives interviewed were satisfied with the laundry service.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	<p>FA</p>	<p>Emergency and disaster policies and procedures are documented for the service. An approved fire evacuation plan is in place. Fire evacuation drills occur every six months. The orientation programme and annual education and training programme include fire training. Staff interviews confirm their understanding of emergency procedures. Required fire equipment was sighted on the day of audit. Fire equipment has been checked within required timeframes.</p> <p>There are adequate supplies readily available in the event of a civil defence emergency including emergency lighting, food, water, blankets and gas cooking.</p> <p>A call bell system is in place. Residents were observed in their rooms with their call bell alarms in close proximity.</p> <p>There is staff available 24 hours a day, seven days a week with a current first aid/CPR certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	<p>FA</p>	<p>General living areas and all resident rooms are appropriately heated and ventilated. All rooms have external windows that open allowing plenty of natural sunlight.</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,</p>	<p>FA</p>	<p>Eversleigh has an established infection control programme. The infection control programme, its content and detail, is appropriate for the size, complexity and degree of risk associated with the service. It is linked into the incident reporting system. The senior nurse is the designated infection control coordinator with support from an infection control committee. The committee includes the senior nurse, a RN, a kitchen hand, the activities coordinator and a caregiver. Infections are discussed at the monthly quality meeting. The infection control programme has been reviewed annually. Infection control education had</p>

and visitors. This shall be appropriate to the size and scope of the service.		not been evidenced as being held in the last 12 months (link 1.2.7.5).
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The senior nurse at Eversleigh is the designated infection control (IC) coordinator. There are adequate resources to implement the infection control programme for the size and complexity of the organisation. The IC coordinator and IC team (comprising RN, kitchenhand, caregiver and activities coordinator) have good external support from the IC nurse specialist at the DHB. Infection prevention and control is part of staff orientation and induction. Hand washing facilities are available throughout the facility and alcohol hand gel is freely available.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	FA	<p>There are infection control policies and procedures appropriate to for the size and complexity of the service. The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes defining roles, responsibilities and oversight, the infection control team and training and education of staff. The policies have been reviewed and updated.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	FA	<p>The infection control policy states that the facility is committed to the ongoing education of staff and residents. There is no documented evidence that formal infection control education for staff has occurred within the last 12 months (link 1.2.7.5). The infection control coordinator has completed infection control training. Visitors are advised of any outbreaks of infection and are advised not to attend until the outbreak has been resolved. Information is provided to residents and visitors that is appropriate to their needs and this is documented in medical records.</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>Infection surveillance and monitoring is an integral part of the infection control programme and is described in policy. The senior nurse is the designated infection control coordinator. Monthly infection data is collected for all infections based on signs and symptoms of infection. Surveillance of all infections is entered onto a monthly resident infection data sheet and then analysed and evaluated. Outcomes and actions are reported to the quality meeting. If there is an emergent issue, it is acted upon in a timely manner. Since the last audit there has been an infectious outbreak, this was reported to the appropriate authorities and appropriately managed.</p>
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>The service has documented systems in place to ensure the use of restraint is actively minimised. There were six residents using a restraint and four residents using an enabler on the day of audit. All restraints and enablers are bed rails. Not all enablers had been classified correctly. The files sampled document that enabler use is voluntary. Not all necessary documentation has been fully completed in relation to the use of restraints and enablers. Staff interviews and staff records evidence guidance has previously been given on restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation techniques but not in the past year. Policies and procedures include definition of restraint and enabler that are congruent with the definition in NZS 8134.0. Staff education on RMSP/enablers has not been provided. Restraint has been discussed as part of quality meetings. A registered nurse is the designated restraint coordinator.</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>	<p>FA</p>	<p>A registered nurse is the restraint coordinator. Assessment and approval process for restraint use included the restraint coordinator, registered nurses, resident or representative and medical practitioner.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is</p>	<p>PA Low</p>	<p>The service completes comprehensive assessments for residents who require restraint or enabler interventions. These were undertaken by suitably qualified and skilled staff, in partnership with the family/whānau, in the six restraint and four enabler files sampled. The restraint coordinator, the resident</p>

undertaken, where indicated, in relation to use of restraint.		and/or their representative and a medical practitioner were involved in the assessment and consent process. In the files reviewed, assessments were fully completed, however the consent process did not include evidence of discussion of the risks associated with enabler or restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	PA Low	The restraint minimisation manual identifies that restraint is only put in place where it is clinically indicated and justified and approval processes are obtained/met. An assessment form/process is completed for all restraints and enablers. Not all files reviewed had a completed assessment form and care plan that reflected risk. Monitoring forms that included regular monitoring at the frequency determined by the risk level were not present in all files reviewed. The service has a restraint and enablers register, which is updated each month.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The service has documented evaluation of restraint at least every three months. In the files reviewed, evaluations had been completed with the resident, family/whānau and restraint coordinator. Restraint practices are reviewed on a formal basis every month by the facility restraint coordinator at quality meetings. Evaluation timeframes are determined by policy and risk levels.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	PA Low	The service actively reviews restraint as part of the internal audit and reporting cycle. Reviews are completed six monthly or sooner if a need is identified. The restraint coordinator completes reviews. Any adverse outcomes are reported at the monthly quality and health and safety meetings.

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 1.2.3.6</p> <p>Quality improvement data are collected, analysed, and evaluated and the results communicated to service providers and, where appropriate, consumers.</p>	PA Low	The organisation has a quality management system in place that schedules the audits and monitoring required. Not all scheduled monitoring or audits had been completed.	Not all internal audits and monitoring identified on the organisation audit planner have been completed.	<p>Ensure that all scheduled audits and monitoring is completed.</p> <p>180 days</p>
<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	Where audit and monitoring results are less than the expected standard corrective action plans (CAPs) are developed for areas requiring improvement. Not all areas requiring improvement had documented corrective action plans in place. Once a corrective	Not all areas for improvement identified through the internal audit and monitoring process had corrective action plans documented or	<p>Ensure that corrective action plans are developed with specific interventions for all areas requiring improvements.</p>

		action plan has been implemented, the corrective action plan is reviewed and signed off as completed by the facility manager. Not all corrective action plans had been reviewed or signed off by the facility manager.	where corrective actions had been noted, the plan/interventions were not specific.	90 days
<p>Criterion 1.2.4.2</p> <p>The service provider understands their statutory and/or regulatory obligations in relation to essential notification reporting and the correct authority is notified where required.</p>	PA Low	The service was unaware of the reporting requirements under section 31 of the Health and Disability Services (Safety) 2001 Act. The section 31 notifications were completed on day of audit.	Essential notifications were not completed for one incident referred to the coroner in June 2015 and one incident referred to the police in November 2015.	<p>Ensure that all the contractual and legal reporting requirements are met.</p> <p>60 days</p>
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve service delivery, and to identify and manage risk.</p>	PA Low	All resident accident/incidents are reported on the correct form. Not all residents had neurological assessments as required by the organisations falls policy documented.	There is no evidence of the neurological observations (PERL) noted on the incident form as being completed for four hospital residents, following an unwitnessed fall and there were no timeframes specified for the	<p>Ensure that neurological assessments are completed as required by the organisations falls policy.</p> <p>90 days</p>

			neurological assessments to be continued.	
<p>Criterion 1.2.7.2</p> <p>Professional qualifications are validated, including evidence of registration and scope of practice for service providers.</p>	PA Low	An annual performance review is required to be completed for all staff, however not all staff had evidence of an annual performance review in the staff files sampled.	Three of five staff files reviewed that should have had an annual performance review completed, had no evidence a performance review had been completed in the past 12 months.	<p>Ensure that all staff have an annual performance review.</p> <p>90 days</p>
<p>Criterion 1.2.7.3</p> <p>The appointment of appropriate service providers to safely meet the needs of consumers.</p>	PA Low	The organisational policy requires that all new staff have police vet checks completed as part of the recruitment process, however, this was not always evidenced.	Two new staff recently recruited had not had the mandatory police vet checks completed.	<p>Ensure that the organisational requirement for all new staff to have police vet checks is followed.</p> <p>60 days</p>
<p>Criterion 1.2.7.4</p> <p>New service providers receive an orientation/induction programme that covers the essential components of the service provided.</p>	PA Low	The organisation has a comprehensive orientation/induction programme for all new staff; however, in the staff files reviewed not all staff have completed the organisational orientation requirements. All staff are	i) Two of two new staff had no evidence that they had completed the organisations orientation requirements.	<p>i) Ensure that all new staff complete the orientation/induction process.</p> <p>ii) Ensure that all staff have a signed</p>

		required to have signed job descriptions which outline the requirements of their role. Not all staff had signed job descriptions on file.	ii) Three of seven staff files sampled do not have signed job descriptions on file.	job description. 60 days
<p>Criterion 1.2.7.5</p> <p>A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	PA Moderate	The service has an annual education planner that has scheduled education to cover the requirements of the Age Related Resident Contract. Not all topics outlined on the schedule have been delivered. Where training has occurred staff attendance has been low.	<p>i) Education has not been provided in the past 12 months for chemical safety training, abuse and neglect prevention, wound management and pressure injury prevention, infection control, and challenging behaviour, and restraint minimisation.</p> <p>ii) Education has not been provided in the past 2 years for advocacy, resident rights, and cultural awareness.</p> <p>iii) Staff attendance numbers have</p>	<p>i) Ensure that the education schedule is fully implemented and education is provided to cover all contractual and legal requirements.</p> <p>ii) Ensure that a process is put in place to ensure that all staff attend mandatory education and where attendance is low an education follow-up plan is implemented.</p> <p>90 days</p>

			been low at the education sessions provided. Where staff have not attended, no follow-up education or training has been provided for mandatory education.	
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	Residents and family/whānau confirmed on interview that they had received all relevant information on admission. The information pack contains information on the service, resident's rights and advocacy brochure. Exclusions from the service are included in the admission agreement.	The amendments made in 2015 to clause D13.3 of the ARRC contract, regarding refund timeframes are not included in the admission agreement currently in use by the service.	<p>Ensure that the current admission agreement aligns fully to the ARRC contract.</p> <p>90 days</p>
<p>Criterion 1.3.3.3</p> <p>Each stage of service provision (assessment, planning, provision, evaluation, review, and exit) is provided within time frames that safely meet the needs of the consumer.</p>	PA Low	Registered nurses complete initial assessments within 24 hours of admission and initial care plans are implemented. InterRAI assessments were not all completed within 21 days of admission. Long-term care plans reviewed were completed within three weeks of admission by	Three of the six files reviewed were new residents since July 2015. All three had InterRAI assessments completed but	<p>Ensure all InterRAI assessments are completed within required timeframes.</p> <p>180 days</p>

		registered nurses.	none were within 21 days of admission.	
<p>Criterion 2.1.1.4</p> <p>The 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.</p>	PA Low	<p>The organisation has policy in place, which includes the definitions of restraint and enablers. Not all enablers in use were classified correctly according to the policy definitions. All residents using a restraint or enabler sign a consent form for the use of a restraint or enabler. The section detailing the risks associated with the use of the enabler or restraint was not fully completed. Education on restraint minimisation is scheduled on the annual education planner but has not been delivered (link 1.2.7.5).</p>	<p>Two of four residents using bed rails as enablers were incorrectly classified and the bedrails were being used as restraints.</p>	<p>Ensure that all enablers and restraints being used comply with the definitions in the organisational policy and the Restraint Minimisation and Safe Practice Standards NZS 8134.0.</p> <p>90 days</p>
<p>Criterion 2.2.2.1</p> <p>In assessing whether restraint will be used, appropriate factors are taken into consideration by a suitably skilled service provider. This shall include but is not limited to:</p> <p>(a) Any risks related to the use of restraint;</p> <p>(b) Any underlying causes for the relevant behaviour or condition if known;</p> <p>(c) Existing advance directives the consumer may have made;</p> <p>(d) Whether the consumer has been restrained in the past and, if so, an evaluation of these episodes;</p> <p>(e) Any history of trauma or abuse, which may have involved the consumer being held against their will;</p>	PA Low	<p>The registered nurse undertakes an assessment for residents requiring the use of a restraint or enabler, however the risks associated with the use of the restraint or enabler were not always documented.</p>	<p>For six residents using restraint and four residents using enablers, the potential risks associated with the use of restraint and enablers was not documented and discussed, as part of the</p>	<p>Ensure that all assessments for restraint use identify and document the risks associated with the use of the restraint or enabler and these risks are discussed with the resident and family/whānau.</p>

<p>(f) Maintaining culturally safe practice; (g) Desired outcome and criteria for ending restraint (which should be made explicit and, as much as practicable, made clear to the consumer); (h) Possible alternative intervention/strategies.</p>			assessment and consent process.	60 days
<p>Criterion 2.2.3.4</p> <p>Each episode of restraint is documented in sufficient detail to provide an accurate account of the indication for use, intervention, duration, its outcome, and shall include but is not limited to:</p> <p>(a) Details of the reasons for initiating the restraint, including the desired outcome; (b) Details of alternative interventions (including de-escalation techniques where applicable) that were attempted or considered prior to the use of restraint; (c) Details of any advocacy/support offered, provided or facilitated; (d) The outcome of the restraint; (e) Any injury to any person as a result of the use of restraint; (f) Observations and monitoring of the consumer during the restraint; (g) Comments resulting from the evaluation of the restraint.</p>	PA Low	Each resident using a restraint or enabler is required to have a restraint care plan in place however, not all residents using a restraint or an enabler had a restraint care plan in place. Not all monitoring required whilst using a restraint was documented.	<p>(i) The restraint and enabler care plans do not document the risks associated with the use of the restraint or enabler and no interventions were documented to manage the identified risk</p> <p>(ii) One resident currently using a restraint has no restraint care plan in place.</p> <p>(iii) Two hourly monitoring of the resident whilst using a restraint was not consistently evidenced in four of six residents using a restraint.</p>	<p>(i-ii) Ensure that all residents using a restraint or enabler have a care plan documented that outlines interventions to cover the assessed care needs and identified risks.</p> <p>(iii) Ensure that all monitoring required is implemented and consistently documented.</p> <p>60 days</p>

<p>Criterion 2.2.5.1</p> <p>Services conduct comprehensive reviews regularly, of all restraint practice in order to determine:</p> <ul style="list-style-type: none"> (a) The extent of restraint use and any trends; (b) The organisation's progress in reducing restraint; (c) Adverse outcomes; (d) Service provider compliance with policies and procedures; (e) Whether the approved restraint is necessary, safe, of an appropriate duration, and appropriate in light of consumer and service provider feedback, and current accepted practice; (f) If individual plans of care/support identified alternative techniques to restraint and demonstrate restraint evaluation; (g) Whether changes to policy, procedures, or guidelines are required; and (h) Whether there are additional education or training needs or changes required to existing education. 	<p>PA Low</p>	<p>The service has a policy in place, which requires an annual review of organisations restraint minimisation and safe practice programme. A review of the programme was not completed.</p>	<p>An annual review of the restraint minimisation and safe practice programme has not been completed as required by the organisational policy.</p>	<p>Ensure that the restraint minimisation programme is reviewed in accordance with the organisational policy.</p> <p>60 days</p>
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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.