

# Oceania Care Company Limited - Everill Orr Village

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## Introduction

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

The audit has been conducted by Central Region's Technical Advisory Services Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

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

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

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Everill Orr Rest Home

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

**Dates of audit:** Start date: 30 May 2016 End date: 31 May 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:** 56

# Executive summary of the audit

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## Introduction

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

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

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

### Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	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
Red	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

Everil Orr Village (Oceania Care Company Limited) can provide care for up to 67 residents requiring care at either rest home or hospital level with 56 residents on the day of audit. This surveillance audit has been undertaken to establish compliance with a subset of the relevant Health and Disability Services Standards and the district health board contract.

The audit process included the review of policies and procedures, the review of residents and staff files, observations and interviews with residents, family, management, staff and a medical officer.

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

All requirements identified at the previous audit around the building, curtains and heating have been addressed.

This surveillance audit identified an improvement required to evidence of resolution of issues when identified in meeting minutes.

## 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 interviewed are able to demonstrate an understanding of residents' rights and obligations, including the complaints process. Information regarding the complaints process is available to residents and their family. Complaints reviewed are investigated with documentation completed and stored in the complaints folder. Staff communicate with residents and family members following any incident with this recorded in the resident file. Residents and family state that the environment is conducive to communication including identification of any issues.

## Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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Everil Orr Village has documentation of the Oceania quality and risk management system that supports the provision of clinical care and support. Policies are reviewed and business status reports allow for the monitoring of service delivery. Benchmarking reports include clinical indicators, incidents/accidents, infections and complaints with an internal audit programme implemented.

Staffing levels are adequate across the service with human resource policies implemented. This includes evidence of recruitment and staffing. Rosters indicate that staff are replaced when on leave.

## 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.



Standards applicable to this service fully attained.

Provision of care is coordinated to promote continuity of service delivery. The residents and family interviewed confirm their input into care planning and access to a range of life experiences and choices. Sampling of residents' clinical files validated service delivery to the residents. Resident's care planning is changed according to the needs of the resident when progress is different from expected. The service uses short term care plans for acute problems.

Residents and family interviewed confirm satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

Medication areas, including controlled drug storage, evidence a secure medicine dispensing system. Review of staff competencies confirmed all staff have current medication management competencies. None of the residents were self-administering their medicines at time of audit. Three monthly medicines reviews are completed for all residents.

Food, fluid, and nutritional needs of residents are provided in line with recognised nutritional guidelines. Additional nutritional and dietary requirements are being met. There is a central kitchen and on-site staff that provide the food services. The kitchen manager confirmed that kitchen staff have completed food safety training.

## 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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There is a current building warrant of fitness. A planned and reactive maintenance programme is in place with issues addressed as these arise. Residents and family interviewed describe the environment as appropriate with indoor and outdoor areas that meet their needs.

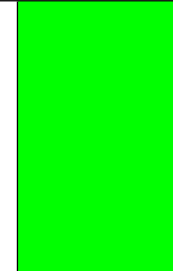
## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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Restraint minimisation policy and procedures are congruent with the restraint minimisation and safe practice standard. Documentation of restraints and enablers includes identification of risks and monitoring time frames. There is a job description for the restraint coordinator and the service is maintaining a restraint register. There is one resident using restraint and one resident using an enabler in the facility.

## 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.

Surveillance of infections is occurring, according to the providers policies, which suits their size and service type. Data on the nature and frequency of identified infections is collated and analysed. The results of surveillance are reported through all levels of the organisation, including governance and benchmarked against other Oceania facilities. The clinical manager is the infection control nurse for the facility.

## Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
<b>Standards</b>	0	17	0	1	0	0	0
<b>Criteria</b>	0	42	0	1	0	0	0

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



# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) and include periods for responding to a complaint. Complaint forms are available at the entrance. A complaints register is in place and the register includes: the date the complaint is received; the source of the complaint; a description of the complaint; and the date the complaint is resolved.</p> <p>Evidence relating to each lodged complaint is held in the complaint's folder. Two complaints in 2016 reviewed indicate that the complaints are investigated promptly with the issues resolved in a timely manner. The complainants in both cases stated that the complaint had been resolved to their satisfaction.</p> <p>The business and care manager is responsible for managing complaints. Residents and family state that these are dealt with as soon as they are identified. Residents and family members state that they have laid complaints in the past with the management team and they feel that they are listened to, with issues resolved.</p> <p>There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit. There is evidence that family can access advocacy services, if they require, to support the complaints process.</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	<p>FA</p>	<p>Accidents/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures guide staff on the process to ensure full and frank open disclosure is available. Family are informed if the resident has an incident, accident, has a change in health or a change in needs, as evidenced in completed accident/incident forms.</p> <p>Family contact is recorded in residents' files. Interviews with family members confirm they are kept informed. Family also confirm that they are invited to the care planning meetings for their family member and could attend the residents' meetings.</p> <p>Residents or family sign an admission agreement on entry to the service. Those reviewed were signed on the day of admission. The admission agreement provides clear information around what is paid for by the service and by the resident.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	<p>FA</p>	<p>Everil Orr Village is part of the Oceania Care Company Limited with the executive management team including: the chief executive; general manager; regional manager; operations manager and clinical and quality manager providing support to the service.</p> <p>Communication between the clinical and quality manager, operations manager, the business and care manager and the clinical manager takes place on at least a monthly basis. The clinical and quality manager provided support during the audit. The monthly business status report provides the executive management team with progress against identified indicators.</p> <p>There is a clear mission, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff orientation and training.</p> <p>The facility can provide care for up to 67 residents with 56 beds occupied at the audit. This included 19 residents requiring rest home level care and 37 requiring hospital level care. Four residents were identified as being under the young people with disability contract.</p> <p>The business and care manager is responsible for the overall management of the service. The business and care manager is a registered nurse with a current annual practicing certificate, has an advanced diploma in nursing and certificate in education and has been in the role for 12 months. The business and care manager has 19 years' experience in management roles and in care of the older adult.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p>	<p>PA Low</p>	<p>Everil Orr Village uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice.</p>

<p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>		<p>The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews, as required, with all policies current. Head office reviews all policies with input from business and care managers. Policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced based best practice guidelines. A document control system is in place. Policies are readily available to staff in hard copy. New and revised policies are presented to staff to read and staff sign to evidence that they have read and understood them. The policy around pressure injuries (PI) has been updated, ratified and staff have been informed of the new policy. The registered nurses confirm that they have read and understood the policy.</p> <p>Service delivery is monitored through review of complaints, incidents and accidents, surveillance of infections, PIs, soft tissue/wounds, and implementation of an internal audit programme. The corrective action plans are documented and there is evidence of the resolution of issues, when issues are identified, in most cases. An improvement is required to documentation of the resolution of issues. There is documentation that includes collection, collation, and identification of trends and analysis of data. Internal audits around PIs are completed six monthly.</p> <p>There are monthly meetings including: staff/quality improvement; clinical; restraint and infection control. There are three monthly resident meetings and family are able to come to the resident meetings, if they wish. There is evidence of attendance by staff at meetings with meeting minutes put in the staffroom for staff to read. There are monthly clinical indicator reports with data tabled at meetings.</p> <p>The satisfaction survey for family and residents in 2016 shows that they are satisfied or very satisfied with services provided and this was confirmed by residents and family interviewed.</p> <p>The organisation has a risk management programme in place. Health and safety policies and procedures are documented along with a hazard management programme. There is evidence of hazard identification forms completed when a hazard is identified. Hazards are addressed or risks minimised or isolated. Health and safety is audited throughout the year with a facility health check completed by the clinical and quality manager. Any issues are identified in the health check, a corrective action plan put in place and evidence of resolution of issues documented.</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</p>	<p>FA</p>	<p>The business and care manager is aware of situations in which the service would need to report and notify statutory authorities, including, police attending the facility; unexpected deaths; sentinel events; notification of a pressure injury; infectious disease outbreaks and changes in key managers. The Ministry of Health and district health board would be notified of any sentinel event. One sentinel event reviewed indicates that appropriate authorities have been notified.</p> <p>Staff receive education at orientation and as part of the ongoing training programme on the incident and accident reporting process. Staff understand the adverse event reporting process and are able to describe</p>

<p>where appropriate their family/whānau of choice in an open manner.</p>		<p>the importance of recording near misses.</p> <p>Incident reports documented had a corresponding note in the progress notes to inform staff of the incident. Information gathered around incidents and accidents is analysed with evidence of improvements put in place.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	<p>FA</p>	<p>The registered nurses (RN), business and care manager and the clinical manager hold current annual practising certificates, along with other health practitioners involved with the service.</p> <p>Staff files include appointment documentation including: signed contracts; job descriptions; reference checks and interviews. There is an appraisal process in place with staff files indicating that all have an annual appraisal.</p> <p>All staff complete an orientation programme and health care assistants are paired with a senior health care assistant for shifts or until they demonstrate competency on a number of tasks including resident's personal cares. Health care assistants confirm their role in supporting and buddying new staff.</p> <p>Annual competencies are completed by clinical staff including: hoist; oxygen use; hand washing; wound management; medication management; moving and handling; restraint; nebuliser; blood sugar and insulin; and assisting residents to shower. Evidence of completion of competencies is kept on staff files.</p> <p>The organisation has a mandatory education and training programme with an annual training schedule documented. Staff attendances are documented for training provided. Education and training hours are at least eight hours a year for each staff member. Five of the eight RNs have completed interRAI training, as has the clinical manager. Three others are waiting for placement in the next enrolment. Staff have completed training around pressure injuries (PI) in 2015 with staff receiving training around PIs in 2016 when they complete the day training programme.</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>The staffing policy is the foundation for work force planning. Staffing levels are reviewed for anticipated workloads, identified numbers and appropriate skill mix, or as required due to changes in the services provided and the number of residents. Rosters sighted reflected staffing levels meeting resident acuity and bed occupancy. Staffing has been organised to reflect the needs of hospital and rest home residents in varying wings of the hospital. The clinical manager's office is used as a base for registered nurses (RN) when there are residents requiring hospital level care at the opposite end of the building from where the nurse's stations are located.</p> <p>There are 56 staff including clinical staff, a staff member who facilitates the activities programme and household staff. There is always a RN on each shift with a second RN rostered on morning and afternoon</p>

		<p>shifts. The business and care manager and the clinical manager are on call. The business and care manager and the rosters confirmed that staff could be brought in for extra time for special residents requiring this, if needed.</p> <p>Residents and families interviewed confirm staffing is adequate to meet the residents' needs.</p> <p>A review of the rosters confirmed that staff are replaced when on leave by casual or bureau staff.</p>
<p><b>Standard 1.3.12: Medicine Management</b></p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>Medication areas, including controlled drug storage evidence an appropriate and secure medicine dispensing system, free from heat, moisture and light, with medicines stored in original dispensed packs. The controlled drug register is maintained and evidences weekly checks and six monthly physical stocktakes. The medication fridge temperatures are conducted and recorded.</p> <p>Current medication competencies for staff who administer medicines were sighted. The medication round was observed and evidenced the staff member was knowledgeable about the medicines administered and signed off, as the dose was administered. Administration records are maintained, as are specimen signatures. Standing orders are current. Medication records meet legislative requirements.</p> <p>Medication audits have been conducted and corrective actions are implemented following the audits. There were no residents self-administering medicines. Three monthly medicines reviews were conducted for the residents within the required timeframes.</p>
<p><b>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</b></p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>In interview, the kitchen manager confirmed they are aware of the residents' individual dietary needs. The residents' files demonstrate monthly monitoring of individual resident's weight. In interviews, residents stated they are satisfied with the food service and reported their individual preferences are met and adequate food and fluids are provided. Interview with the kitchen manager confirmed kitchen staff have completed food safety training, and this was verified by their food safety certificates.</p> <p>On inspection, the kitchen environment was clean, well lit and uncluttered. There was evidence of kitchen cleaning schedules, signed off as cleaning is completed. Fridge, chiller and freezer temperatures are monitored regularly and recorded, as are food temperatures. There is a seasonal menu, last reviewed by a dietitian on 4 April 2016. Review of residents' files, dietary profiles and kitchen documentation showed evidence of residents being provided with nutritional meals and meals such as special diets, pureed meals along with alternative nutrition appropriate to the residents are available.</p> <p>There was enough stock to last in an emergency situations, for three days, for all residents.</p>

<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	<p>FA</p>	<p>The residents' person's centred care plans (PCCP) evidence the required interventions, desired outcomes and/or their goals. The general practitioner (GP) documentation and records are current. Interviews with residents and family confirm their and their relatives' current care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained.</p> <p>Staff members confirm during interview that they are familiar with the current interventions of the residents they were allocated.</p>
<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The service employs one activities coordinator (AC) who oversees residents' activity programmes in both the rest home and the hospital. Interview with the AC confirmed a activities programme is available to each residents in the hospital and rest home. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities, including festive occasions and celebrations.</p> <p>There are activities assessments and activities care plans in residents' files reviewed. The service has four residents under the contract for younger people and all have additional activities catered to their needs. Activities care plans in the residents' files reviewed had intervention relating to the activities goals. The residents' activities attendance records are maintained, as are activities progress notes.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>In interviews, residents and family confirm their participation in care plan evaluations and multidisciplinary reviews. The residents' progress records are entered on each shift. When resident's progress is different than expected, the RN contacts the GP, as required. Short term care plans were sighted in some of the residents' files, and these are used when required. The family are notified of any changes in resident's condition, confirmed at family interviews. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.</p>
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	<p>FA</p>	<p>A current building warrant of fitness is displayed – expiry date April 2017.</p> <p>One building (the Astley wing) has been demolished since the last audit with a building site contained by the contracted company. Noise levels because of the construction site are being monitored. There have been no building modifications to other parts of the building since the last audit although there has been refurbishment of rooms. There is a planned maintenance schedule implemented. The following equipment is available: pressure relieving mattresses; shower chairs; hoists and sensor alarm mats. There is an annual test and tag programme and this is up to date with checking and calibrating of clinical equipment</p>

		<p>annually. Interviews with staff and observation of the facility confirm there is adequate equipment.</p> <p>There are quiet areas throughout the facility for residents and visitors to meet and there are areas that provide privacy, when required. There are courtyards and grass areas with shade, seating and outdoor tables.</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>	FA	<p>There are toilet, showering and bathing facilities in close proximity to all bedrooms with a staff and visitors toilets near reception. One single room and one double room had been refurbished at the previous audit. Both had residents in them and neither had the curtains replaced. Both rooms were checked on the day of the audit and both had curtains that had been replaced. All rooms have curtains on windows and curtains to separate bed areas in double rooms. The previous requirement identified at the partial provisional audit has been met.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>Rooms in the facility are ventilated and heated in a way that maximises resident comfort. Heaters identified as being too hot at the previous audit have had cages put in place that protect any person intending to touch them. One boiler has been decommissioned with heating options replaced by electric heaters in bedrooms and oil filled heaters in communal areas. Residents and family interviewed confirm that there is adequate heating and ventilation. The previous improvement identified at the partial provisional audit around heating has been addressed.</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>	FA	<p>The clinical manager (CM) is responsible for the surveillance programme for this service. Clear definitions of surveillance and types of infections (for example; facility-acquired infections) are documented to guide staff. Information is collated on a monthly basis. Surveillance is appropriate for the size and nature of the services provided.</p> <p>Information gathered is clearly documented in the infection log maintained by the clinical manager/infection control nurse (ICN). Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control (IC) programme. IC processes are in place and documented. Surveillance results are discussed in the staff meeting. There have been no outbreaks</p>

		since the previous audit.
<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>The definition of restraint and enabler is congruent with the definition in the standard. There is a job description for the position of the restraint coordinator who is the clinical manager.</p> <p>Staff interviews, observations, and review of documentation, demonstrated safe use of restraint and enablers. The service has a policy of actively minimising restraint. The service has a documented system in place for restraint and enabler use, including a current restraint register. There was one resident using restraints and no enablers being used in the facility on audit days.</p>



## Specific results for criterion where corrective actions are required

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

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

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

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.8</p> <p>A corrective action plan addressing areas requiring improvement in order to meet the specified Standard or requirements is developed and implemented.</p>	PA Low	The business and care manager and the clinical manager document corrective action plans with evidence of resolution of issues when these are identified through the internal audit process. At times, corrective actions, when identified in meeting minutes, include sign off indicating that they have been resolved. At times also, the issues are carried over to the next meeting with evidence that these have been addressed.	Corrective actions identified in meeting minutes are not always signed off indicating that the issue has been resolved.	<p>Ensure that when issues are identified through meeting minutes they are consistently signed off to indicate that the issue has been resolved.</p> <p>180 days</p>

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

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

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

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

No data to display
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End of the report.