

# Oceania Care Company Limited - Franklin Rest Home

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## Introduction

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

The audit has been conducted by 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:

<b>Legal entity:</b>	Oceania Care Company Limited
<b>Premises audited:</b>	Franklin Rest Home
<b>Services audited:</b>	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care); Dementia care
<b>Dates of audit:</b>	Start date: 30 August 2016 End date: 31 August 2016
<b>Proposed changes to current services (if any):</b>	None
<b>Total beds occupied across all premises included in the audit on the first day of the audit:</b>	43

# Executive summary of the audit

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## Introduction

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

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

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

### Key to the indicators

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

Indicator	Description	Definition
	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

## General overview of the audit

Franklin Village (Oceania Care Company Limited) can provide care for up to 44 residents. This certification audit was conducted against the Health and Disability Service Standards and the service contract with the district health board.

Occupancy on the day of the audit was 43. The service provides rest home, hospital and dementia care.

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 regional and executive management team. Service delivery is monitored. The service met all the Health and Disability Service Standards.

## 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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Information regarding the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), the complaints process and the Nationwide Health and Disability Advocacy Service, is accessible. This information is given to residents and their family on admission to the facility. Residents and family members confirm their rights are met, staff are respectful of their needs and communication is appropriate.

Residents, families and enduring power of attorney are provided with information required prior to giving informed consent. Time is provided if any discussions and explanation are required relating to the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).

A complaints register is maintained. Complaints are managed as per timeframes in the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code).

## 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.		Standards applicable to this service fully attained.
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Oceania Care Company Limited is the governing body and is responsible for the service provided at Franklin Village. The business and care manager is qualified and experienced. The business and care manager is supported by the clinical leader who are responsible for oversight of clinical care. Oceania Care Company Limited has a documented quality and risk management system that supports the provision of clinical care at the service. Policies are reviewed at support office and are current.

Quality and risk performance is reported through meetings at the facility and monitored by the organisation's management team through the business status reports.

Benchmarking reports are produced that include incidents/accidents, infections, complaints and clinical indicators.

There are human resource policies implemented around recruitment, selection, orientation, staff training and development

Staff, residents and family confirm that staffing levels are adequate and residents and relatives have access to staff when needed. Staff are allocated to support residents as per their individual needs.

## Continuum of service delivery

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.
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Residents receive services from suitably qualified and experienced staff. Assessments are completed within required timeframes and interRAI assessments are up-to-date. Care plan evaluations are documented, resident-focused and indicate progress towards meeting residents' desired outcomes. Where progress of a resident is different from expected, the service responds by initiating changes to the long term care plan. Short-term problems are recorded on short-term care plans. Residents and their family have opportunity to contribute to care planning and reviews.

Recreational assessments and recreational plans are completed for residents. Activities are planned and there is evidence of input to the activities programme by a diversional therapist. The activities programme is available to residents in all residents in the facility.

The medication management system evidences processes comply with legislation, guidelines and protocols for reconciliation, prescribing, administration, dispensing, storage and disposal of medicines. Medicine management training is conducted as part of the in-service training programme. The service does not have any residents who self-administer medicines. All staff responsible for medicines management have current medication competencies.

Food and nutritional needs of residents are provided and are in line with recognised nutritional guidelines. Menus are reviewed by a dietitian. Food service complies with current legislation and guidelines.

## 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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All building and plant comply with legislation, with a current building warrant of fitness in place. The environment is appropriate to the needs of the residents. A preventative and reactive maintenance programme includes equipment and electrical checks. Residents are provided with accessible and safe external areas. Residents' rooms are of an appropriate size to allow for care to be provided and for the safe use and manoeuvring of mobility aids. Essential emergency and security systems are in place, with regular fire drills completed. Call bells allow residents to access help, when needed, in a timely manner.

## Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.		Standards applicable to this service fully attained.
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The restraint minimisation policy and procedures and the definitions of restraint and enabler are congruent with the restraint minimisation and safe practice standard. There were two residents using restraint and one resident requiring an enabler on audit days. Assessment, care planning, evaluation and monitoring of restraint and enabler use is being conducted. Staff education in restraint, de-escalation and challenging behaviour is provided.

## Infection prevention and control

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

Standards applicable to this service fully attained.

Infection prevention and control, including surveillance, is occurring according to the provider's policies. Infection prevention and control policy suits their size and service type. Data on the nature and frequency of identified infections is collected, collated and analysed. The results of surveillance are reported through all levels of the organisation. The service reports infection surveillance data as part of key quality information to the governing body. The service participates in benchmarking against other Oceania Care Company Limited facilities.

## 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	50	0	0	0	0	0
<b>Criteria</b>	0	101	0	0	0	0	0

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Residents stated that they receive services that meet their needs and they receive information relative to their needs. They stated that staff respect their wishes.</p> <p>Staff receive education on the Health and Disability Commissioner (HDC) Code of Health and Disability Services Consumers' Rights (the Code) during their induction to the service and through the annual mandatory education programme. All staff have had training in the Code in 2016.</p> <p>Interviews with the staff confirmed their understanding of the Code. Examples were provided on ways the Code is implemented in their everyday practice including: maintaining residents' privacy; giving residents' choices; encouraging independence and ensuring residents can continue to practice their own personal values and beliefs.</p> <p>The auditors noted respectful attitudes towards residents on the days of the audit.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate their family/whānau of choice are provided with</p>	FA	<p>There is an informed consent policy and procedure that directs staff in relation to gathering of informed consent. Staff ensure that all residents are aware of treatment and interventions planned for them, and the resident and/or significant others are included in the planning of that</p>

<p>the information they need to make informed choices and give informed consent.</p>		<p>care.</p> <p>All resident files identified that informed consent is collected. Interviews with staff confirmed their understanding of informed consent processes.</p> <p>The service information pack includes information regarding informed consent. The business and care manager (BCM) and clinical leader (CL) discuss informed consent processes with residents and their families during the admission process.</p> <p>The policy and procedure includes guidelines for consent for resuscitation/advance directives and resuscitation orders are completed for residents when applicable.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Resident information around advocacy services is available at the entrance to the service and in information packs provided to residents and family on admission to the service. Written information on the role of advocacy services is also provided to complainants at the time when their complaint is acknowledged. Staff training on the role of advocacy services was last provided in 2016.</p> <p>The health and disability advocate visits the service, as confirmed by the management team. Family and residents confirmed that the service provides opportunities for the family/enduring power of attorney (EPOA) to be involved in decisions and they state that they have been informed about advocacy services.</p> <p>Family members in the dementia unit confirmed that they act as advocates for their family member and also for other residents if they identify any needs. They state that the management team appreciates their input.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>The service has an open visiting policy. Residents may have visitors of their choice at any time. The facility is secured in the evenings and visitors can arrange to visit after doors are locked. Families confirmed they could visit at any time and are always made to feel welcome.</p> <p>Residents are encouraged to be involved in community activities and to maintain family and friend networks. Residents' files reviewed demonstrate that progress notes and the content of care plans include regular outings and appointments.</p>
<p>Standard 1.1.13: Complaints Management</p>	<p>FA</p>	<p>The organisation's complaints policy and procedures are in line with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code), and</p>

<p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>		<p>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. Evidence relating to each lodged complaint is held in the complaints folder. The complaint was reviewed and indicated that the complaint was investigated promptly with the issues resolved in a timely manner. Staff, residents and family confirmed they knew the complaints process.</p> <p>The business and care manager is responsible for managing complaints and residents and family stated that these are dealt with as soon as they are identified. Residents and family members are able to describe their rights and advocacy services particularly in relation to the complaints process.</p> <p>There have been no complaints lodged with the Health and Disability Commission or other external authorities since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The business and care manager (BCM) and the clinical leader (CL) discuss the Code, with residents and their family on admission. Discussion relating to the Code is also included on the agenda and discussed at the residents' meetings. Resident and family interviews confirmed their rights are being upheld by the service. Information on the Code is given to next of kin or enduring power of attorney (EPOA) to read and discuss with the resident in private. The posters identifying residents' rights and advocacy services are displayed in the facility in te reo Māori and English.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>The service has a philosophy that promotes dignity, respect and quality of life. The service has policies and procedures that are aligned with the requirements of the Privacy Act and Health Information Privacy Code. Residents' support needs are assessed using a holistic approach. The initial and ongoing assessments gain details of residents' beliefs and values, with care plans completed with the resident and/or the family member. Interventions to support these are identified and evaluated.</p> <p>The service ensures that each resident has the right to privacy and dignity. The residents' own personal belongings are used to decorate their rooms. Discussions of a private nature are held in the resident's room and there are areas in the facility which can be used for private meetings.</p> <p>A policy is available for staff to assist them in managing resident practices and/or expressions of sexuality and intimacy in an appropriate and discreet manner with strategies documented to</p>

		<p>manage any inappropriate behaviour if there are any issues for a resident.</p> <p>Health care assistants report that they knock on bedroom doors prior to entering rooms, ensure doors are shut when cares are being given and do not hold personal discussions in public areas. This was observed on the days of the audit. Residents and families confirmed that residents' privacy is respected.</p> <p>The service is committed to the prevention and detection of abuse and neglect by ensuring provision of quality care. Staff receive annual training on abuse and neglect and can describe signs. There are no documented incidents of abuse or neglect in the business status reports for 2016 or on the incidents reviewed in residents' files. Residents, staff, family and the general practitioner confirmed that there was no evidence of abuse or neglect. Staff interviewed were aware of the need for them to ensure residents are not exploited, neglected or abused and staff can describe the process for escalating any issues.</p> <p>Resident files reviewed confirmed that cultural and/or spiritual values and individual preferences are identified.</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>	<p>FA</p>	<p>The organisation has a cultural responsiveness policy which outlines the processes for working with people from other cultures. Specifically a Māori health plan outlines how to work with Māori and the relevance of the Treaty of Waitangi. The rights of the residents/family to practise their own beliefs are acknowledged in the Māori health plan.</p> <p>Staff who identify as Māori are able to provide support for Māori residents and their families, if needed. Three of the Māori staff speak fluent te reo Māori. A review of residents' files confirmed that specific cultural needs are identified in the residents' care plans. The business and care manager (BCM) stated that a kaumātua can be accessed by the service to support staff on tikanga protocols and general advice.</p> <p>Staff are aware of the importance of whānau in the delivery of care for the Māori residents.</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>	<p>FA</p>	<p>The service identifies each resident's personal needs from the time of admission. This is achieved with the resident, family and/or their representative. There is a culture of choice with the resident determining when cares occur, times for meals and choices in meals and activities. Staff work to balance service delivery, duty of care and resident choice.</p> <p>Residents and family are involved in the assessment and the care planning processes. Information gathered during assessment includes the resident's cultural values and beliefs.</p>

		<p>This information is used to develop a care plan.</p> <p>Staff are familiar with how translating and interpreting services can be accessed. Residents in the service did not require interpreting services on audit days. Residents who identify as Māori and Pacific Island state that they receive services that meet their cultural needs.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>The facility implements the Oceania Care Company Limited (Oceania) policies and procedures to ensure staff are aware of good practice and boundaries relating to discrimination, abuse and neglect, harassment and exploitation. Mandatory staff training includes discussion of the staff code of conduct and prevention of inappropriate care. Staff interviewed stated that they are aware of the policies and are active in identifying any issues that relate to the policy.</p> <p>Residents and family stated that they would formally complain to management if they felt that they were discriminated against. There were no complaints recorded in the complaints register for the previous 12 months relating to any form of discrimination.</p> <p>Job descriptions include: responsibilities of the position; ethics; advocacy and legal issues with a job description sighted in staff files reviewed relevant to the role held by the staff member. The orientation and employee agreement provided to staff on induction include standards of conduct. Interviews with staff confirmed their understanding of professional boundaries, including the boundaries of the health care assistants and senior health care assistance role and responsibilities.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service implements Oceania policies to guide practice. These policies align with the Health and Disability Services Standards. A quality framework supports an internal audit programme. Benchmarking occurs across all the Oceania facilities. Oceania's clinical and quality managers for the regions have quarterly cluster meetings to evaluate the quality programme and projects that are being implemented.</p> <p>There is a training programme for all staff and managers are encouraged to complete management training.</p> <p>Residents and families expressed a high level of satisfaction with the care delivered.</p> <p>Consultation is available for the service through the organisation's management team that includes: registered nurses; the clinical and quality manager; regional manager and a dietitian.</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>Accident/incidents, the complaints procedure and the open disclosure procedure alert staff to their responsibility to notify family/enduring power of attorney of any accident/incident that occurs. These procedures 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 confirmed they are kept informed. Family also confirmed that they are invited to the care planning meetings for their family member and can attend the residents' meetings. News letters are sent to all families three monthly and Oceania news letters are sent out every two months. Families confirmed they are well informed.</p> <p>Residents sign an admission agreement on entry to the service. This provides clear information around what is paid for by the service and by the resident. The admission agreements reviewed were signed on the day of admission.</p> <p>Family of residents in the dementia unit state that they can raise any issues on behalf of their family and believe that these are followed up promptly.</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>Franklin Village is part of the Oceania Care Company Limited (Oceania) 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. Communication between the service and managers takes place on at least a monthly basis with the clinical and quality manager providing support during the audit. The monthly business status report provides the executive management with progress against identified indicators.</p> <p>The organisation's mission statement and philosophy are displayed at the entrance to the facility. Information in booklets is given to new residents and staff training is provided annually.</p> <p>The service has a business and care manager (BCM) supported by a clinical leader (CL). The CL has been in the position for six years and holds a current annual practising certificate. The BCM holds a current annual practising certificate and a diploma in business management, has been in aged care for fourteen years and in the current position for six years.</p>
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an</p>	<p>FA</p>	<p>In the absence of the BCM, the CL is in charge with support from the regional operations manager and clinical and quality manager (organisational).</p>

<p>efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		
<p><b>Standard 1.2.3: Quality And Risk Management Systems</b></p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>Franklin Village uses the Oceania Care Company Limited (Oceania) quality and risk management framework to guide practice. The service implements organisational policies and procedures to support service delivery. All policies are subject to reviews as required with all policies current. Oceania support 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. 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 the new/revised policy.</p> <p>Service delivery is monitored through: complaints; review of incidents and accidents; surveillance of infections; pressure injuries; soft tissue/wounds; and implementation of an internal audit programme. The corrective action plans are documented and evidence resolution of issues completed. There is documentation that includes collection, collation, and identification of trends and analysis of data. Internal audits are completed in line with the quality audit schedule, with evidence of corrective actions identified and implemented.</p> <p>Monthly staff meeting minutes including quality improvement, health and safety and infection control, evidence communication with all staff around all aspects of quality improvement and risk management. There are monthly resident meetings coordinated by the diversional therapist that keep residents informed of any changes. Staff report that they are kept informed of quality improvements. Family are invited to come to the resident meetings.</p> <p>The satisfaction survey for family and residents in 2016 shows a high level of satisfaction and this was confirmed by residents and family.</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 monthly with a facility health check completed quarterly by the clinical and quality manager. Any issues are identified, a corrective action plan put in place and evidence of resolution of issues.</p>
<p><b>Standard 1.2.4: Adverse Event Reporting</b></p>	<p>FA</p>	<p>The BCM is aware of situations in which the service is required to report and notify statutory authorities, including unexpected deaths, police attending the facility, sentinel events,</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>		<p>infectious disease outbreaks and changes in key management roles. Staff interviews and review of documentation evidence that staff document adverse, unplanned or untoward events on an accident/incident form which are signed off by the BCM. Following analysis, corrective actions are implemented and completed. Incidents have a corresponding note in the progress notes to inform staff of the incident. There have been no deaths referred to the coroner or essential notifications to Ministry of Health (MoH) and district health board (DHB) since the last audit.</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 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 personal cares. Health care assistants confirm their role in supporting and budding new staff. A new staff member interviewed confirming that they had a comprehensive orientation programme.</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; 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 internal training provided with some registered nurses and health care assistants attending.</p> <p>Education and training hours are at least eight hours a year for each staff member. Two of the five registered nurses have interRAI training and staff have completed training around pressure injuries in 2016.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate,</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</p>

<p>and safe service from suitably qualified/skilled and/or experienced service providers.</p>		<p>staffing levels meet resident acuity and bed occupancy.</p> <p>There are 38 staff, including the management team, clinical staff, a diversional therapist, and household staff. There is always a registered nurse on each shift. The BCM and CL are on call for afterhours.</p> <p>Residents and families confirm staffing is adequate to meet the residents' needs.</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 service retains relevant and appropriate information to identify residents and track records. This includes information gathered on admission, with the involvement of the family.</p> <p>There are policies and procedures in place for privacy and confidentiality. Staff described the procedures for maintaining confidentiality of resident records, relevant resident care, and support information can be accessed in a timely manner.</p> <p>Entries are legible, dated and signed by the relevant health care assistant, registered nurse or other staff member, including their designation.</p> <p>Resident files are protected from unauthorised access by being locked away in an office.</p> <p>Information containing sensitive resident information is not displayed in a way that could be viewed by other residents or members of the public. Individual resident files demonstrate service integration. This included medical care interventions. Medication charts are in a separate folder with medication. Staff state that they read the short-term and long-term plans and are informed of any changes through the handover process.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	<p>FA</p>	<p>There is a pre-entry to service process that is managed by the business and care manager (BCM) with the assistance of the clinical leader (CL). The BCM and CL are able to assist residents and family members in understanding the various levels of care, funding requirements and the process of needs assessment. Organisational information packs are available with all appropriate documentation for those enquiring about the service, and/or entering the service.</p> <p>Families are contacted in a timely manner when a bed becomes available. On entry to the service the service agreement is signed and dated and full orientation of the facility is provided to the resident/family or representative.</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>Planned exits, discharges or transfers are coordinated in collaboration with the resident and family. There are documented policies and procedures to ensure exit, discharge or transfer of residents is undertaken in a timely and safe manner. The CL reported that they include copies of the resident's records; including GP visits; medication charts; current long-term care plans; upcoming hospital appointments, and other medical alerts when a resident is transferred to another health provider.</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 policy identifies all aspects of medicine management. 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 evidenced weekly checks and six monthly physical stocktakes. The medication fridge temperatures are checked and recorded.</p> <p>All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff members were knowledgeable about the medicine administered. Administration records are maintained, as are specimen signatures. Staff education in medicine management is conducted.</p> <p>Medicine charts evidence residents' photo identification, legibility, as required (PRN) medication is identified for individual residents and correctly prescribed, three monthly medicine reviews are conducted and discontinued medicines are dated and signed by the GP. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given). There were no residents self-administering medicines at the facility.</p> <p>Medication errors are reported to the RN and recorded on an incident form. The resident and/or the designated representative are advised. There is a process for comprehensive analysis of any medication errors, and compliance with this process is verified.</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>In interview, the cook confirmed they were 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. Residents' individual preferences are met and adequate food and fluids are provided. Interview with the cook 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 in 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. There was enough stock to last in an emergency situations, for three days, for all residents. Residents in the dementia unit are provided with additional snacks throughout the day and at night.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	FA	<p>The service provides rest home, hospital and dementia level of care including twenty four hours of care, seven days a week. Declining a referral does not occur often due to the variety of services offered. Family are assisted in finding appropriate service provider to meet the needs of the resident, if there are no beds available. The BCM and CL assist with this process during the pre-entry process.</p>
<p>Standard 1.3.4: Assessment</p> <p>Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	FA	<p>On admission, residents have their needs identified through collection of data including: the needs assessment and service coordination (NASC) agency; other service providers involved with the resident; the resident; family/whānau and on-site assessments using a range of assessment tools, including interRAI assessment.</p> <p>The information gathered is documented to inform the initial care planning process. The RN undertakes an interRAI assessment and other assessments over three weeks to complete the person centred care plan (PCCP). The PCCP provides long-term care planning and is reviewed six monthly or when the resident's needs change.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>The PCCP reviewed were individualised, integrated and up to date. The PCCPs record assessment findings and describe the required support and interventions the resident needs to meet their goals and desired outcomes.</p> <p>PCCP evidence service integration with progress notes, activities notes and GP and allied health staff notations recorded. Regular GP care is implemented, evidenced in progress reports and confirmed at the GP interview.</p>

		Short-term care plans are developed, when required, and signed off by the RN or clinical leader when problems are resolved. Staff reported they receive adequate information for continuity of residents' care. The residents and/or their family have input into their care planning and review.
<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>	FA	The person's centred care plans (PCCP) evidence the required interventions, desired outcomes or goals of the residents. The GP documentation and records are current. Residents and family confirmed that relatives' care and treatments meet their needs. Family communication is recorded in the residents' files. Nursing progress notes and observation charts are maintained. Staff confirmed they are familiar with the needs of the resident they were allocated.
<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>	FA	<p>The activities programme ensures residents' individual motivational, recreational and cultural needs are recognised. Each resident is assessed by the diversional therapist (DT) on admission. The residents have the opportunity to maintain interests, choices and activities in a continuing care environment. A copy of the monthly activities programme is reviewed and signed off by the diversional therapist.</p> <p>The DT confirmed that resident participation is voluntary and this is respected by staff. A recreation attendance list is maintained. Residents are encouraged to maintain links with family and the community at every opportunity. There are outings arranged each week with a van outing register and consents for outings are obtained. Special days, such as birthdays and special holidays, are celebrated.</p> <p>The service has a chaplain available for church services which are held weekly. At the time of the audit residents were visibly enjoying activities in the different units and residents interviewed reported that they enjoy the variety of planned activities arranged.</p> <p>Residents in the dementia unit have 24 hour activity plans for the management of challenging behaviour. Care staff provide activities to residents in the dementia unit after hours or when the DT is not available.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely</p>	FA	<p>Timeframes in relation to care planning evaluations are documented. In interviews, residents and family confirmed their participation in care plan evaluations and multidisciplinary reviews.</p> <p>The residents' progress notes are entered on each shift. When residents' progress is different</p>

manner.		than expected, the RN contacts the GP as required. Short-term care plans were sighted in residents' files, and these are used when required. The family are notified of changes in resident's condition. There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required.
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are provided with options if required to access other health and disability services. Examples of referrals were seen in the individual resident records reviewed. Copies of all referrals are retained in the records. Specialist medical and surgical referrals are arranged as needed. There is a process for transferring residents, if and when required. The district health board (DHB) referral system is followed through and is a guide for the GP and staff after hours, as needed.</p> <p>The clinical leader (CL) and RNs interviewed reported that referral services respond to referrals sent in a timely manner. Records of the processes maintained was confirmed in the residents' records reviewed, which includes referrals and consultations to specialist appointments radiology services, geriatricians/nurse practitioners, dietitians and other health professionals, when required. The GP interviewed reported that appropriate referrals to other health and disability services are well managed.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.</p>	FA	<p>Documented processes for the management of waste and hazardous substances are in place and incidents are reported on in a timely manner. Policies and procedures specify labelling requirements in line with legislation including the requirement for labels to be clear, accessible to read and are free from damage.</p> <p>Material safety data sheets are available throughout the facility and accessible for staff. The hazard register is current. Staff receive training and education in safe and appropriate handling of waste and hazardous substances.</p> <p>There is provision and availability of protective clothing and equipment that is appropriate to the recognized risks, for example: goggles/visors; gloves; aprons; footwear; and masks. Clothing is provided and used by staff. During a tour of the facility, protective clothing and equipment was observed in all high-risk areas.</p> <p>Chemicals are stored in a designated shed with chemical hazard signs.</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. There have been no building modifications since the last audit, although there has been refurbishment of the facility as part of the Oceania's facilities upgrade programme referred to as Homely Homes, including an upgrade to the kitchen and one of the garden court yards.</p> <p>There is a planned and reactive 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 annually.</p> <p>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 two internal courtyards and grass areas with shade, seating and outdoor tables.</p> <p>There is a secure unit for residents with dementia, one entrance with a key pad access internally and one exit into a secure courtyard.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	<p>FA</p>	<p>There are adequate numbers of accessible toilets/bathing facilities. All toilet facilities have a system that indicates if it is engaged or vacant.</p> <p>Appropriately secured and approved handrails are provided in the toilet/shower/bathing areas, and other equipment/accessories are made available to promote resident independence.</p> <p>Auditors observed residents being supported to access communal toilets and showers, in ways that are respectful and dignified.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided in all bedrooms to allow residents and staff to move around within the room safely. Residents spoke positively about their rooms. Equipment was sighted in rooms requiring this with sufficient space for the equipment, staff and the resident.</p> <p>Rooms can be personalised with furnishings, photos and other personal adornments and the service encouraged residents to make the suite their own.</p> <p>There are designated areas to store mobility aids, hoists and wheelchairs. The hospital rooms and assisted care rooms are large enough to accommodate specific aids.</p>

<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	FA	<p>The service has lounge/dining areas including areas that can be used for activities. All areas are easily accessed by residents and staff. Residents are able to access areas for privacy, if required. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.</p> <p>The dining areas have ample space for residents. Residents can choose to have their meals in their room.</p> <p>The dementia unit has its own dining room and lounge area, with residents in the dementia unit encouraged to join in some activities held in the main hospital/rest home area.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>Laundry is completed off site, and is delivered daily. Laundry is transported in appropriate colour coordinated linen bags. Laundry staff sort the personal laundry in the evening and health care assistants are required to return linen to the rooms. Residents and family members confirmed that the laundry is well managed. There are cleaners on site during the day, seven days a week. The cleaners have a lockable cupboard to put chemicals in and are aware that the trolley must be with them at all times. Cleaners were observed to be vigilant on the days of the audit particularly in the dementia unit around keeping the trolley in sight and limiting the chemical cleaning agents on the trolley to one bottle.</p> <p>All chemicals are in appropriately labelled containers. Products are used with training about the use of products provided throughout the year. Cleaning is monitored through the internal audit process with no issues identified in audits.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>An evacuation plan was approved by the New Zealand Fire Service in August 2005. An evacuation policy on emergency and security situations is in place. A fire drill is conducted six monthly. The last fire training was completed in April 16. The orientation programme includes fire and security training. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the day of audit and all equipment had been checked within required timeframes.</p> <p>There is always one registered nurse with a current first aid certificate on duty.</p> <p>A disaster management plan is in place with clear information for staff to follow in the event of an emergency. There are adequate supplies, including food, water, blankets, emergency</p>

		<p>lighting and gas BBQ.</p> <p>An electronic call bell system is in place. There are call bells in all resident rooms, resident toilets, and communal areas including the hallways and dining rooms. Call bell audits are routinely completed. Observation on the days of audit and interviews with residents and family confirmed there are prompt responses to call bells. Sensor mats are used where appropriate.</p> <p>Staff complete a check in the evening that confirms that security measures have been put in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.</p>	FA	<p>There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation, wherever practicable. Residents are provided with adequate natural light, safe ventilation, heating and an environment that is maintained at a safe and comfortable temperature.</p> <p>There is a designated external smoking area for residents.</p> <p>Family and residents confirm that rooms are maintained at an appropriate temperature.</p>
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control policy and procedures provide information and resources to inform staff on infection prevention and control.</p> <p>The delegation of infection control matters is documented in policies, along with an infection control nurse's (ICN) job description. The infection control nurse is a registered nurse. There is evidence of regular reports on infection related issues and these are communicated to staff and management. The infection control programme is reviewed annually.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The ICN reports to management monthly and trends or issues identified are shared with staff. External specialist advice from the contracted GPs, the laboratory microbiologist and the ICN specialists at DHB is available, as required. The GP interviewed is informed of obligations and reporting systems, if needed, for notifiable infections outbreaks of disease or illness. There have been no outbreaks of infection since the last audit. Guidelines, policies and procedures are in place for staff to follow should an incident arise.</p>

<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>	<p>FA</p>	<p>The infection control policies and procedures are relevant to the service and reflect current accepted good practice and relevant legislative requirements. Policies are accessible to all personnel. The infection control policies and procedures are developed and reviewed regularly in consultation and input from relevant staff, and external specialists. Infection control policies and procedures identify links to other documentation in the facility.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control education is provided to all staff, as part of their orientation and as part of the ongoing in-service education programme. In interviews, staff advised that clinical staff identify situations where infection control education is required for a resident such as: hand hygiene; cough etiquette; and one on one education is conducted. A registered nurse completed additional training for the role as the infection control coordinator (ICC). The infection control staff education is provided by the ICN, RNs and external specialists. Education sessions have evidence of staff attendance/participation and content of the presentations. Staff are required to complete infection control competencies, sighted in staff files and confirmed at staff interviews.</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>Surveillance is in line with the organisation's policies and the requirements for infection prevention and control as set out in the NZS 8134.3:2008: Health and Disability Services (Infection Prevention and Control) Standards. Infections are recorded as quality indicators on the intranet. Residents with infections have short-term care plans completed to ensure effective management and monitoring of infections. Quality indicators are reported on a monthly basis at staff, quality, infection control and health and safety meetings.</p> <p>The type of surveillance undertaken is appropriate to the size and complexity of this service. Standardised definitions are used for the identification and classification of infection events. Infection summary logs are maintained for infection events in individual resident's files reviewed. In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the RNs, verbal handovers and progress notes.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	<p>FA</p>	<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. The restraint coordinator is the clinical leader.</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 were two restraints and one enabler being used in the facility on audit days.</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>All relevant legislation and requirements for restraint, inclusive of definitions and safe and appropriate guidelines for management of the use of restraint, is documented. The processes implemented reflect the safe use of restraint and enablers.</p> <p>Restraint approval is made in conjunction with the registered nurse, the GP and the restraint coordinator. There is a flow chart available which clearly outlines the processes for restraint/enabler approval. A restraint assessment authorisation and plan is completed by the registered nurse Resident input is sought as applicable. The form outlines the conditions for the use of the restraint/enabler and verifies this has been explained to the resident/family/whānau.</p> <p>For all residents for whom restraint/enablers are being used, evaluation is undertaken to gauge the effectiveness or otherwise of restraint/enabler as an appropriate safe intervention. The resident/family/whānau are involved in the evaluation process. The evaluations are completed three monthly.</p> <p>Staff confirm their understanding and use of the restraint in the person centred care plan. Education is provided to all staff in the form of a workshop and education covers alternatives to restraint/enabler use and management of restraint minimisation and safe practice.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	<p>FA</p>	<p>Restraint assessments include restraint related risks. The service records issues contributing to the need for safety that may require restraint with a focus on: culturally safe practices; identification of desired outcomes; and possible alternatives to restraint. Restraint risks and monitoring timeframes are identified in the restraint assessment records.</p>
<p>Standard 2.2.3: Safe Restraint Use</p>	<p>FA</p>	<p>Before the use of restraint, the restraint coordinator utilises other means to minimise risk, for</p>

Services use restraint safely		example, the use of sensor mats. Restraint consents are signed by the GP, family and the restraint coordinator. The GP confirmed that the facility uses restraint safely.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	The restraint coordinator evaluates all episodes of restraint. Reviews include the effectiveness of the restraint in use, restraint-related injuries and whether the restraint is still required. The family are involved in the evaluation of the restraints' effectiveness and reviews. Documentation was sighted in the progress notes regarding restraint related matters. Restraint minimisation and safe practices are reviewed.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring and quality review of their use of restraint.	FA	<p>Three monthly monitoring and annual quality reviews are conducted relating to the use of restraint/enablers. Restraint team meetings are held monthly. Senior staff and registered nurses attend. The restraint coordinator reports to management and to support office on a monthly basis. Quality review findings and any recommendations are used to improve service provision and resident safety. The restraint minimisation policies are current and are available to guide staff.</p> <p>The restraint minimisation and safe practice education provided for all staff is managed and staff attend in-service training on a regular basis, as documented in the education programme. Records are maintained by the restraint coordinator.</p>

## Specific results for criterion where corrective actions are required

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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.

No data to display
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## Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display
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End of the report.