The Ultimate Care Group Limited - Rosedale Village Hospital

Introduction

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

The audit has been conducted by The DAA Group 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:	The Ultimate Care Group Limited
Premises audited:	Rosedale Village Hospital
Services audited:	Hospital services - Medical services; Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 16 November 2016 End date: 17 November 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

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

Ultimate Care Rosedale provides residential care for up to 64 residents who have been assessed as requiring hospital or rest home level care. On the first day of audit there were 56 beds occupied, 22 of which are under an occupational right agreement. The Ministry of Health have approved all occupied apartments. The facility is operated by the Ultimate Care Group Limited.

This certification audit has been undertaken to establish compliance with the Health and Disability Services Standard and the district health board contract. The audit process included review of policies and procedures, review of residents' and staff files, observations and interviews with residents, families, management, staff, a general practitioner and other allied health professionals.

There are no areas requiring improvement from this audit.

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.

The Health and Disability Commissioner`s Code of Health and Disability Services Consumers` Rights (the Code) is made available to residents. Opportunities to discuss the Code, consent and availability of advocacy services is provided at the time of admission and thereafter as required.

Services are provided that respect choices, personal privacy, independence, individual needs and dignity of residents and staff were noted to be interacting with residents in a respectful manner.

Residents who identify as Maori have their needs met in a manner that respects their cultural values and beliefs. A comprehensive Maori Health plan and related policies guide care. There is no evidence of abuse, neglect or discrimination and staff understood and implemented related policies. Professional boundaries are maintained.

Open communication between staff and families is promoted, and confirmed to be effective. There is access to formal interpreting services if required.

The service has linkages with a range of specialist health providers, which contributes to ensuring services to residents are of an appropriate standard.

The facility manager is responsible for the management of complaints and a complaints register is maintained. There have been no investigations by the Health and Disability Commissioner or other external agencies since the previous audit.

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.

The Ultimate Care Group Limited is the governing body and is responsible for the service provided. A business plan and quality and risk management systems are fully implemented at Ultimate Care Rosedale and include a documented scope, direction, goals,

values, and a mission statement. Systems are in place for monitoring the service, including regular reporting by the facility manager and clinical services manager to head office.

The facility is managed by a facility manager who has a background in management. The facility manager is supported by a clinical services manager who is a registered nurse. The clinical services manager is responsible for oversight of the clinical service in the facility.

Quality and risk management systems are in place. There is an internal audit programme. Adverse events are documented on accident/incident forms. Accident/incident forms and quality meeting minutes evidenced corrective action plans are developed, implemented, monitored and signed off as being completed to address the issue/s that require improvement. Quality, staff and resident meetings are held on a regular basis.

The hazard register evidenced review and updating of risks and the addition of new risks. The health and safety representative has completed an update on the Health and Safety at Work Act (2015) requirements.

Human resources processes are followed. There are policies and procedures on human resources management. Staff have the required qualifications. An in-service education programme is provided and staff performance is monitored.

The documented rationale for determining staffing levels and skill mixes is based on best practice. Registered nurses are rostered on duty at all times. The clinical services manager and facility manager are on call after hours.

Residents` information is accurately recorded, securely stored and not accessible to unauthorised people. Up-to-date, legible and relevant resident records are maintained.

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.

The organisation works closely with the local Needs Assessment and Service Co-ordination Service, to ensure access to the facility is appropriate and efficiently managed. When a vacancy occurs, sufficient and relevant information is provided to the potential resident/family to facilitate an admission.

Residents` needs are assessed by the multidisciplinary team on admission within the required timeframes. Registered nurses are on duty 24 hours each day and are supported by care and allied health staff and a designated general practitioner. Shift handovers and communication sheets guide continuity of care.

Care plans are individualised based on an integrated range of clinical information. Short term care plans are developed to manage any problems that might arise. All residents` records reviewed demonstrated that needs, goals and outcomes are identified and reviewed on a regular basis. Family interviewed reported being well informed and involved in the care planning and evaluation, and that the care provided is of a high standard. Residents are referred or transferred to other health and disability services as required, with appropriate handovers.

The planned activities programmes are supported by three activities coordinators one of whom is a qualified diversional therapist. The activities staff provide residents with a variety of individual and group activities and maintain their links with the community. A facility van and a bus are available for outings in the community.

Medicines are managed according to policies and procedures based on current good practice and are consistently implemented using a manual system. Registered nurses and one enrolled nurse administer medications, all of whom have been assessed as competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. A food safety plan and policies guide food service delivery, supported by staff with food safety training provided every two years. The kitchen is well organised, clean and meets all food safety standards.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.

All building and plant complies with legislation. A current building warrant of fitness is displayed. A preventative and reactive maintenance programme includes equipment and electrical checks.

Single accommodation is provided. Adequate numbers of additional bathrooms and toilets are available. There are a number of lounges, dining areas and alcoves. External areas for sitting and shading is provided.

An appropriate call bell system is available and security and emergency systems are in place.

Protective equipment and clothing is provided and used by staff. Chemicals, soiled linen and equipment were safely stored. All laundry is washed on site. Cleaning and laundry systems, including appropriate monitoring is undertaken to evaluate the effectiveness of these services.

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.

The service has clear policies and procedures that meet the requirements of the restraint minimisation and safe practice standard. There were residents using restraint and enablers during the audit. Appropriate documentation including a current restraint register was in place.

Infection prevention and control

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

The infection prevention and control programme is led by two registered nurses who have completed training and aim to prevent and manage infections. There are terms of reference for the infection control committee which meets quarterly. Specialist infection prevention and control advice is accessed from the district health board and a microbiologist from the laboratory service, as required. The programme is reviewed annually.

Staff demonstrated good principles and practice around infection control, which is guided by relevant policies and supported with regular education.

Aged care specific infection surveillance is undertaken, analysed, trended and benchmarked and results reported through all levels of the organisation. Follow-up action is taken as and when required.

Summary of attainment

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

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	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)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

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

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

For more information on the standards, please click here.

For more information on the different types of audits and what they cover please click here.

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	The Code of Rights policy defines a list of residents' rights that are congruent with the Health and Disability Commissioner`s (HDC) Code of Health and Disability Services Consumers` Rights (the Code). The service policy states the Code is displayed and available to residents and monitored to ensure the rights of the residents are respected. New residents and family/whanau are given a copy of the Code on admission in the information pack sighted. The Code is displayed in all service areas in full view of residents, caregivers and visitors to the facility. Staff receive training on the Code at commencement of employment as part of the orientation/induction process. The clinical staff interviewed demonstrated knowledge on the Code and its implementation in their day to day practice. The Code is available in English, Maori and other languages for residents with English as a second language.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they	FA	There is an informed consent policy which includes a definition of informed consent and references a range of documents associated to the topic. There is a procedure to guide staff. There is an organisation wide informed consent form for care and treatment, permission to collect and store information and to release information as required. In addition, there are other informed consent

need to make informed choices and give informed consent.		forms used on a daily basis. Some examples are the transportation consent form, flu vaccination (annually) permission is required, training and participation consent and other forms. Residents are given the opportunity to participate and/or to decline. The general practitioner has a policy to use to guide when verifying resident competency and how to assess whether a resident is deemed medically capable of informed consent decision making or not. Enduring Power of Attorney records are kept if available in the appropriate section in the resident`s individual record in case this is needed.
Standard 1.1.11: Advocacy And Support Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.	FA	There is a resident advocacy policy which describes a process of identifying a new resident`s support person, including family/whanau or representative. The advocacy policy is available to guide staff. The policy also makes reference to the complaints procedure. All residents receiving care have appropriate access to independent advice and support, including access to a spiritual advocate if required. Family interviewed reported they were provided with all relevant information regarding access to advocacy services. Contact details of the Nationwide Health and Disability Advocacy Service is listed in the resident information pack provided. The contact numbers are also documented on the reverse of the Consumers` Rights brochure. Education for staff is conducted as part of the orientation programme and is ongoing and this was sighted in the education and training programme and confirmed by staff interviewed.
Standard 1.1.12: Links With Family/Whānau And Other Community Resources Consumers are able to maintain links with their family/whānau and their community.	FA	Visitors are able to visit anytime and families interviewed confirmed they are encouraged to visit. A visitor`s book is situated at reception and this is completed by visitors for health and safety reasons. Residents are supported and encouraged to access community services with visitors or as part of the planned activities programme. This was observed in the activity programme records reviewed and reported by residents interviewed.
Standard 1.1.13: Complaints Management The right of the consumer to make a complaint is understood, respected, and upheld.	FA	The complaints policy and associated forms meet the requirements of Right 10 of the Code. The information is provided to residents on admission and there is complaints information and forms available within the facility. The complaints register showed nine complaints have been received over the past year and that actions taken, through to an agreed resolution, are documented and completed within the timeframes specified in the Code. Action plans reviewed show any required follow up and

		improvements have been made where possible.
		The facility manager is responsible for complaints management and follow up. Staff interviewed confirmed a sound understanding of the complaint process and what actions are required.
		The facility manager (FM) and the national quality manager reported there have been no investigations by the Health and Disability Commissioner, the Ministry of Health, DHB, Accident Compensation Corporation (ACC), Coroner or Police since the previous audit.
Standard 1.1.2: Consumer Rights During Service Delivery Consumers are informed of their rights.	FA	A copy of the Code and information about the Nationwide Health and Disability Advocacy Service is provided to all residents and their respective family and/or representative on admission and the registered nurse discusses the Code during the admission process.
		The family members that were available for interview reported that the Code was explained to them on admission. Interviews with residents who were able to provide insight into their care, expressed that they are treated with all respect and dignity and were pleased with their care and management.
		An interpreter policy was reviewed and an interpreter service is available through the DHB and a nationwide 24 hour service is contactable if required. Staff interviewed have a good understanding of consumer rights.
		Evidence is seen of the Code being displayed throughout the facility in all service areas. Staff were observed and demonstrated respect to residents. Staff discussed and have knowledge of the significance of the Code during all aspects of service delivery.
Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.	FA	The wishes of residents are acknowledged and are reflected in the care plans reviewed. Independence is maximised and maintained along with dignity and respect. The privacy policy requires staff to be respectful of the residents own personal space in this long term care setting at all times. The privacy officer is the facility manager. The staff and the GP interviewed indicated that residents received services that are responsive to their needs, values and beliefs of culture, religion and ethnicity. Residents from other nationalities are being cared for at this facility. The resident`s ethnicity is recorded in the resident register and on the individual resident records reviewed.
		The families interviewed reported satisfaction with the way the service meets the needs of their relatives and that their relatives are treated in a manner showing regard to the individual resident`s dignity, privacy and independence.
		As observed on the days of the audit and confirmed with the review of the residents' records, all

		needs and interventions to achieve goals are documented to guide staff. There is a policy on elder abuse and neglect which describes how staff ensure that no resident is subjected to abuse or neglect. This includes definitions of abuse and neglect and the process of reporting suspected abuse and/or neglect by verbally reporting to the registered nurse on duty and writing an accident/incident report form. The general practitioner stated there are no concerns that have been raised in relation to abuse and neglect. Staff have received education as per the education and training records and at interview clearly understood their responsibilities. Comments received from residents/family and staff reflect a caring, friendly, welcoming and positive atmosphere.
Standard 1.1.4: Recognition Of Māori Values And Beliefs 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.	FA	The service has a Maori Health Plan which acknowledges the Treaty of Waitangi and states the service will provide an effective health service for Maori people which includes the three principles of the Treaty. The organisation is committed to identifying the needs of all residents and ensuring staff are adequately trained to identify if any barriers are observed for Maori accessing the service. There are currently no known barriers for Maori accessing this service. All Maori residents if admitted to this service have a cultural needs assessment performed to identify any specific beliefs, needs and values. The service encourages the holistic view on Maori health and this is incorporated into the delivery of services. Staff interviewed are fully informed about tikanga, kawa, karakia and waiata best practice and these are respected. Guidelines are developed and implemented to ensure guidance is available for the provision of culturally safe services for Maori residents. Rooms are able to be blessed as required. There are no residents or staff who identify as Maori at the time of this audit. The staff demonstrated a good understanding of providing services that would need to be provided for Maori residents to meet their identified needs, and the significance and importance of whanau centred care.
Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.	FA	The recognition of individual beliefs and values policy describes the process of including each person`s own values and beliefs into their care plan and doing this with family/whanau input if this is the person`s choice. Staff are provided regular training in supporting residents to achieve their values and beliefs and in assisting them to practice any cultural activities which they choose. The cultural needs assessment tool is available to ensure all identified needs can be effectively met. The staff recognise and respect the cultural needs of residents in their everyday practices. Staff interviewed reported they have received training in cultural awareness and the training was

		verified in the training records reviewed.
Standard 1.1.7: Discrimination Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.	FA	There is a guideline for maintaining privacy and dignity and for communicating with residents, relatives and visitors to guide staff. The staff records verified job descriptions and employment agreements that have clear guidelines regarding professional boundaries. House rules are also part of the employment agreement and staff responsibilities were reviewed. There are clear types of discrimination noted and key objectives to be upheld for residents. All registered nurses have completed the professional boundaries workshops which is now a requirement for the New Zealand Nursing Council. The family/whanau/residents interviewed reported they are happy with the care provided.
Standard 1.1.8: Good Practice Consumers receive services of an appropriate standard.	FA	The clinical services manager and the registered nurses promote and encourage best practice with all staff. The registered nurses are taking on additional roles such as with infection prevention and control and restraint minimisation management with enthusiasm and ensuring an evidenced-based learning environment is encouraged. Policies and procedures are managed effectively by the Clinical Advisory Panel for the organisation. Where applicable policies and procedures are linked to evidence-based practice and referenced accordingly. The general practitioner interviewed has discussions with family and/or residents as required. The family and residents reported satisfaction with the service delivery and care provided overall.
Standard 1.1.9: Communication Service providers communicate effectively with consumers and provide an environment conducive to effective communication.	FA	Resident records included evidence of open disclosure and timely communication with residents and families. Communication was documented in family communication sheets, on accident/incident forms as well as documented in the residents' progress notes. Evidence was sighted of both families, and where possible, residents, having input into the care planning process. Staff were observed communicating effectively with residents and families. There are guidelines for communicating with residents, relatives and visitors which sets out expected behaviours of all staff. The cultural awareness policy documents that residents and families who do not speak English shall be advised of the availability of an interpreter at the first point of contact with the service. Interpreter services are available if and when required. The service promotes an environment that optimises communication and staff education related to appropriate communication methods.

		Family interviewed confirmed they are kept informed of the resident`s status, including any events adversely affecting the resident. Evidence of open disclosure is in the resident`s records reviewed, such as on the accident/incident form, the progress records and on the family/whanau communication contact form.
Standard 1.2.1: Governance The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.	FA	The Ultimate Care Group Limited (UCG) is the governing body and is responsible for the service provided at Ultimate Care Rosedale. A quality and risk management plan that includes a business plan was reviewed and included a mission and vision statement, core values, quality objectives, quality indicators and quality projects, and scope of service. An organisational flowchart shows the structure and reporting lines within the organisation. The service philosophy is in an understandable form and was available to residents and their family / representative or other services involved in referring clients to the service. The Ultimate Care Group has established systems in place which defined the scope, direction and goals of the organisation at UCG facilities, as well as the monitoring and reporting processes against these systems. The facility manager's reports to UCG head office includes, but is not limited to, reporting on occupancy, staffing and human resources management, environmental and property reports, financial reporting, interRAI assessments, and general comments. Daily reporting to UCG head office is via an electronic database which is also used by the CSM to input clinical indicators. The facility manager (FM) has been in the position of FM since June 2016. The facility manager has a background in management spanning over 30 years and has held management positions in the private and public sectors both in this country and overseas. The FM is supported by an experienced clinical services manager (CSM) / registered nurse (RN) and a clinical coordinator/RN. The CSM has been in this role since April 2016 and is responsible for oversight of clinical care provided to residents. The CSM has experience in the aged care sector and prior to this appointment has held clinical manager positions in other aged care facilities. The senior management team from UCG head office also provide support as required. Ultimate Care Rosedale is certified to provide 64 beds for either hospital level care or rest home level care. On day one of this audit there were 40 hospital residents of which six were under an occupational rights agreement as well as the 16 rest home residents.
Standard 1.2.2: Service Management The organisation ensures the day-to-	FA	In the absence of the facility manager, the clinical services manager deputises. When the CSM is absent, the clinical coordinator takes responsibility for clinical overview. The FM and the CSM

day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.		confirmed their responsibility and authority for these roles.
Standard 1.2.3: Quality And Risk Management Systems The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.	FA	A quality and risk management plan guides the quality programme and included goals and objectives. An internal audit programme is in place and audits have been completed as per the schedule. Risks are identified, and there is a hazard register that identified health and safety risks as well as risks associated with human resources management, legislative compliance, contractual risks and clinical risk. A Health and Safety Manual was available that included relevant policies and procedures. Clinical indicators and quality improvement data were recorded on various registers and forms. Data is being collected, collated and comprehensively analysed to identify trends. Corrective actions are developed and implemented to improve service delivery following completion of internal audits, surveys, incident/accidents, complaints and any deficits identified at the various meetings. There was good evidence of monitoring to make sure corrective actions have been effective. Interview of the CSM evidenced their sound knowledge relating to quality and risk management. Graphs showed benchmarking with other facilities within the group and another company that provides aged care. Meeting schedules and minutes reviewed evidenced that monthly quality, staff, registered nurse (RN) cleaners and kitchen meetings are held. Resident meetings for rest home/hospital are held every three months. Meeting minutes evidenced reporting of clinical indicators including trends and graphs. The Ultimate Care Group policies and procedures are fully implemented at Ultimate Care Rosedale. Policies and procedures were reviewed that are relevant to the scope and complexity of the service, reflected current accepted good practice, and referenced legislative requirements. The care plan policy includes interRAI requirements. Policies / procedures were available with systems in place for reviewing and updating the policies and procedures regularly, including a policy for document update reviews and document control policy. The clinical advisory panel from UCG is responsible for reviewing policies and procedures. Staff signing sheets demonstrated staff had been updated on new/reviewed policies, and this was confirmed during interviews of care staff. Care staff confirmed the policies and procedures provided appropriate guidance for the service delivery and they were advised of new policies / revised policies. Actual and potential risks are identified and documented in the hazard register. The hazard register identifies hazards and showed the actions put in place to minimise or eliminate risks. Newly found

		hazards are communicated to staff and residents as appropriate. The health and safety coordinator is responsible for hazards and demonstrated good knowledge. Staff confirmed they understood and implemented documented hazard identification processes.
Standard 1.2.4: Adverse Event Reporting All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.	FA	Staff are documenting adverse, unplanned or untoward events on an accident/incident form. The clinical services manager collates these. The original is kept in the residents' files. Documentation reviewed and interviews of staff indicated appropriate management of adverse events. There is an open disclosure policy. Residents' files evidenced communication with families following adverse events involving the resident, or any change in the resident's condition. Families confirmed they are advised in a timely manner following any adverse event or change in their relative's condition. Staff stated they are made aware of their essential notification responsibilities through job descriptions, policies and procedures, and professional codes of conduct. Review of staff files confirmed this. Policy and procedures comply with essential notification reporting. The FM and national quality manager advised there have been no essential notifications (Section 31) made to the Ministry of Health since the previous audit. The national quality manager reported the Ministry has been advised of the change of facility manager and clinical services manager.
Standard 1.2.7: Human Resource Management Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.	FA	Policies and procedures relating to human resources management are in place. Staff files include job descriptions which outline accountability, responsibilities and authority, employment agreements, references, completed orientation, competency assessments, education records and police vetting. The education programme for 2016 was reviewed and is the responsibility of the CSM. There was good evidence of in-service education provided for staff and documentation showed this has been a focus at Ultimate Care Rosedale since the appointment of the CSM. Individual records of education are maintained electronically as are competency assessments. Staff files evidenced education records and competency assessments including restraint and medication management for RNs. Five RNs are interRAI competent. The CSM advised a New Zealand Qualification Authority education programme will be re-introduced in the new year for staff to complete. An orientation/induction programme is available and all new staff are required to complete this prior to their commencement of care to residents. The entire orientation process, including completion of competencies, takes up to three months to complete and staff performance is reviewed at the end

		of this period and annually thereafter. Orientation for staff covers the essential components of the service provided.
		Staff performance appraisals are current. Annual practising certificates are current for all staff and contractors who require them to practice.
		Care staff confirmed they have completed an orientation, including competency assessments. Care staff also confirmed their attendance at on-going in-service education and currency of their performance appraisals.
Standard 1.2.8: Service Provider Availability Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.	FA	There is a documented rationale for determining staffing levels and skill mixes to provide safe service delivery. An electronic system is used that is based on best practice. The FM and CSM reported they review the rosters weekly and consider dependency levels of residents and the physical environment which is on three levels. The minimum number of staff is provided during the night shift and consists of one RN and four care givers. During the day, there is a RN on each of the three floors plus a clinical coordinator and clinical services manager. The FM and CSM are on-call after hours. Care staff interviewed reported there was adequate staff available and that they can get through the work allocated to them. Residents and families interviewed reported the number of staff on duty is adequate to provide them or their relative with safe care. Observations during this audit confirmed adequate staff cover is provided.
Standard 1.2.9: Consumer Information Management Systems Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.	FA	Personal information is entered in all residents' records reviewed. Entries are clearly documented and are legible with dates, signatures and designations as required. The record folders are integrated. A resident register is maintained. The current resident records are stored securely in the nurses' offices which are located upstairs in the hospital wing and downstairs. The offices are both locked when not in use with key pad access only. Resident information is not displayed in public view.
		The facility manager maintains staff files. Checklists in the front of each individual staff and resident's record were sighted. Information is able to be retrieved as required for records over this past year. A system is now in place for accessing any archived records if and when needed.
Standard 1.3.1: Entry To Services Consumers' entry into services is facilitated in a competent, equitable,	FA	Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) service.
		Prospective residents and/or their families are encouraged to visit the facility prior to admission and

timely, and respectful manner, when their need for services has been identified.		meet with the facility manager and/or the clinical services manager. They are provided with written information about the services and the admission process. The organisation seeks updated information from the DHB and the GP for residents accessing respite care. Family members interviewed stated they are satisfied with the admission process and the information that had been made available to them on admission. Records reviewed contained completed information details, assessments and a signed and dated service admission agreements in accordance with contractual requirements and legislation. Where possible these are signed off by the resident and/or their representative.
Standard 1.3.10: Transition, Exit, Discharge, Or Transfer Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.	FA	Exit, discharge or transfer is managed in a planned and coordinated manner, with a nurse escort as appropriate. They can facilitate transfer of residents to and from acute care services. There is open communication between all services and this is encouraged by providing appropriate information, including the medication records, previous x-rays and copies of enduring power of attorney (EPOA) documentation. All referrals are documented in the progress records and a copy of the referral letter is placed in the integrated records for the individual resident concerned. Family are kept informed at all times. The family communication record is completed. When a resident is transferred to the DHB the yellow envelope system is utilised and the front record is completed with all relevant information about the resident.
Standard 1.3.12: Medicine Management Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.	FA	The medication management policy is current and outlines all aspects of medication management. Fifteen registered nurses and one enrolled nurse are medication competent. No care staff administer medication. The rate of medication errors has been actively minimised. A safe system for medication management was observed on the day of the audit. The staff observed demonstrated knowledge and has a clear understanding of their roles and responsibilities in relation to each stage of medication management. Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. The medications are checked by a registered nurse against the prescription. All medications sighted are within current use by dates. Clinical pharmacist input is provided as required. Controlled drugs are stored securely in accordance with legislative requirements. The drugs are checked weekly with two staff one a registered nurse for accuracy in administration. The controlled drug register provided evidence of weekly and six monthly stock checks and accurate entries. Temperature monitoring of the medication fridge was reviewed and temperatures are within the

		recommended range.
		The registered nurses monitor PRN (as required) usage and advise the GP as required for an individual resident. Only one resident is currently self-administering medications. There is a process for comprehensive analysis of any medication errors, and compliance with this process if verified.
		No standing orders are in use during the audit.
Standard 1.3.13: Nutrition, Safe Food, And Fluid Management A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.	FA	The food service is provided on site by employed staff and is in line with recognised nutritional guidelines for older people. A food service manager and two kitchen staff interviewed are experienced in all aspects of food procurement, production, preparation, storage, transportation, delivery and disposal of food. The service providers comply with all current legislation and guidelines available. The service has an approved food safety plan and additional cleaning schedules are followed daily for chores to be completed. Food temperature monitoring, including high risk items, are monitored appropriately and recorded as part of the plan. The chef and the kitchen hands have completed safe food handling training. A nutritional assessment is completed by the registered nurses assigned to residents on admission. A copy of the assessment is forwarded to the kitchen and a dietary profile is developed. The personal food preferences, and special diets are made known to the kitchen staff and accommodated in the daily meal plan. Special equipment and resources are available to meet the nutritional needs of the residents. Evidence of satisfaction with the meal service was verified by family/whanau interviews and some responses from satisfaction surveys. Residents were observed eating their meals at the midday mealtime and sufficient time was given to ensure those requiring assistance had this provided. There is sufficient staff on duty in the dining room at meal times to ensure assistance is available to residents as needed.
Standard 1.3.2: Declining Referral/Entry To Services Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.	FA	If a referral is received whereby a prospective resident does not meet the entry criteria for example for a resident requiring level three dementia care the local NASC is advised to ensure the prospective resident and family are supported to find another appropriate care alternative. This service provides rest home and hospital level care but an assessment is required for a resident to change level of care. A referral for reassessment to the NASC is completed in consultation with the individual resident and the family/whanau. The NASC service and the DHB aged care services work collaboratively together for each individual resident requiring placement.

		The resident register is maintained and was up-to-date.
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Information is documented using validated nursing assessment tools such as the interRAI assessment. In addition, and as required, other assessment tools are readily available to utilise, such as skin integrity assessment, Norton scale risk assessment, nutritional screening, pain scale, Coombes falls assessment and a continence assessment. Other tools are available if needed as a means to identify any deficits and to inform care planning. The sample of care plans reviewed had an integrated range of resident related information. All residents have current interRAI assessments completed by one of the trained registered nurses.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	FA	Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. Lifestyle resident plans reviewed evidence integration with the progress records, activities records, medical and allied health professional`s notations clearly written, informative and relevant. Any change in care required is documented and verbally passes on to relevant staff. Families reported participation in the development and ongoing evaluations of the lifestyle resident care plans.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	Documentation, observations and interviews verified the provision of care to residents is consistent with their needs, goals and the plan of care. The attention to meeting adverse range of resident`s individualised needs is evident in all areas of service provision. The residents' GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed and care is managed effectively. Care staff confirmed that care is provided as outlined in the documentation. A range of equipment and resources is available, suited to the level of care provided in accordance with the residents` needs.
Standard 1.3.7: Planned Activities 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.	FA	There are three coordinators to provide the activities programme for this facility. One staff member is a fully qualified diversional therapist. There are two separate programmes implemented one for the rest home and one for the hospital level residents. A social assessment and history is undertaken on admission to ascertain residents` needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate and activities programme that is meaningful for the residents. The resident`s activity

		needs are evaluated six monthly or more often if required.
		The planned monthly activities programme reviewed matches the skills, likes, dislikes and interests identified in assessment data. Activities reflect residents` goals/objectives, ordinary patterns of life and includes community activities. Activities are provided in groups, and individual one on one activities as required for the frail residents. Community outings are arranged and the service has one van and a bus. A designated driver is available. An activities coordinator is present on all outings. Resident safety is not compromised.
		The resident and family satisfaction surveys demonstrated satisfaction with the activities programme. Any information is used to improve the range of activities offered. Residents interviewed confirmed they find the programme interesting and varied.
Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive and timely manner.	FA	Resident care is evaluated each shift and reported in the progress records. If any changes occur this is reported to one of the registered nurses. The RN documents evaluations. Where progress is different from expected, the service responds by initiating changes to the plan of care. Short term care plans are used and are consistently reviewed and updated until a problem or issue is resolved. Examples of short term care plans being used for wound care, recurrent falls management and/or continence reviews are available in the short term care record folder. Family interviewed provided examples of involvement in the evaluation of progress and any changes as a result.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	Residents are supported to access referral to other health and disability service providers. If the need for other non-urgent services are indicated or requested, the GP sends a referral to seek specialist input. Copies of referrals are sighted in the residents` records reviewed including, mental health services, NASC, DHB dietitians, radiology, medical specialist services and or other health professionals as needed. Referral are followed up on a regular basis by the clinical services manager or the GP. The family and resident if possible are kept informed of the referral process, as verified in documentation and family interviews. Arrangements are made by staff should a resident required an ambulance in a medical emergency.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service	FA	There are documented processes for the management of waste and hazardous substances. Incidents are reported in a timely manner. Policies and procedures specify labelling requirements in line with legislation. Material safety data sheets were sighted throughout the facility and accessible

providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.		for staff. The hazard register is current. There was protective clothing and equipment in the sluice rooms and laundry that is appropriate to recognised risks. Protective clothing was observed being used by staff. Staff interviewed had a sound understanding of processes relating to the management of waste and hazardous substances.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	FA	A current building warrant of fitness is displayed. There are appropriate systems in place to ensure the residents' physical environment and facilities are fit for their purpose. Ultimate Care Rosedale is on three levels. Passage ways are wide and the entire facility is spacious. Residents confirmed they can move freely around the facility and that the accommodation meets their needs. There is a proactive and reactive maintenance programme and the buildings, plant and equipment are maintained to a high standard. Maintenance is undertaken by a maintenance person who has a good understanding of their responsibilities. The testing and tagging of electrical equipment and calibration of bio-medical equipment is current. There are external areas available that are safely maintained and are appropriate to the resident groups and setting. The environment is conducive to the range of activities undertaken in the areas. Residents are protected from risks associated with being outside. Care staff confirmed they have access to appropriate equipment, that equipment is checked before use and they are competent to use it.
Standard 1.4.3: Toilet, Shower, And Bathing Facilities 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.	FA	Bedrooms in the hospital area have a mix of ensuites with a toilet and wash hand basin and bedrooms without an ensuite. There are adequate numbers of additional bathrooms and toilets throughout the facility. The apartments have their own facilities. Residents and families reported that there are sufficient toilets and they are easy to access. Appropriately secured and approved handrails are provided and other equipment is available to promote residents' independence.
Standard 1.4.4: Personal Space/Bed Areas	FA	There is adequate personal space provided for residents and staff to move safely around the bedrooms in the hospital area. The apartments are spacious and provide hospital or rest home level of care. Residents and families spoke positively about their or their relative's accommodation.

Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.		Rooms are personalised with furnishings, photos, and other personal adornments. There is adequate room in the facility to store mobility aids such as mobility scooters, wheel chairs and walkers.
Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.	FA	Numerous areas are provided for residents to frequent for activities, dining, relaxing and for privacy. Residents, families and staff confirmed and observation evidenced these areas are easily accessed. Considerable thought has gone into furnishing the facility. Furniture is appropriate to the setting and arranged in a manner which enables residents to mobilise freely.
Standard 1.4.6: Cleaning And Laundry Services Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.	FA	All laundry is washed on site. Residents and families reported the laundry is managed well and resident's clothes are returned in a timely manner. There are small areas on each floor for personal laundry. Ultimate Care Rosedale is cleaned to a high standard. There are dedicated cleaners on site who have received appropriate education. The cleaners stated they take great pride in the way the facility is presented. Residents and families stated the facility is "spotless". The 2016 satisfaction survey confirmed this. Chemicals are stored in a locked cupboard. All chemicals were in appropriately labelled containers. Cleaning and laundry processes are monitored through the internal audit programme and by personnel from the external company that supplies the chemicals.
Standard 1.4.7: Essential, Emergency, And Security Systems Consumers receive an appropriate and timely response during emergency and security situations.	FA	There is an approved fire evacuation plan. There is an evacuation policy on emergency and security situations that covers all service groups at the facility. A fire drill takes place six-monthly. The orientation programme includes fire and security education. Staff confirmed their awareness of emergency procedures. All required fire equipment was sighted on the days of audit and all equipment had been checked within required timeframes. There is always at least one staff member on duty with a current first aid certificate. A civil defence plan is in place. There are adequate supplies in the event of a civil defence emergency including food, water, blankets, cell phones and gas BBQs. Back up lighting and power is available should there is a power outage. There are call bells to alert staff. Residents and families reported staff respond promptly to call

		bells.
		Contractors must sign in and out of the facility. They are also made aware of any hazards on site and complete an orientation to the facility. The external doors lock automatically in the evenings and a security company checks the facility at night.
Standard 1.4.8: Natural Light, Ventilation, And Heating Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and comfortable temperature.	FA	There are procedures to ensure the service is responsive to resident feedback in relation to heating and ventilation. Heat pumps and electric heaters provide heating. Residents are provided with safe ventilation, and an environment that is maintained at a safe and comfortable temperature. All resident areas are provided with natural light. Residents and families reported the temperature is always comfortable.
Standard 3.1: Infection control management 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.	FA	The service has a documented infection prevention and control programme which is implemented. The infection prevention and control programme aims to minimise risk of infections to residents, family/whanau, staff and visitors to the facility. Reference and resource material is available to staff. The programme is appropriate for the size and nature of this residential aged care facility. The infection control coordinator and clinical services manager are experienced registered nurses. The role includes monitoring all infections, using standardised definitions to identify infections and to carry out surveillance monitoring of organisms, related to antibiotic use. Monthly records are maintained. Infection prevention and control is presented at each staff meeting. The infection control coordinator interviewed has a good understanding of the early detection of suspected infections. Care staff interviewed are skilled and ensure that they notify the registered nurses of any concerns when caring for the residents. The shift handovers are also a forum to report any incidences of infection. Short term care plans are documented as required. There is an infection record held in each of the selected resident`s records reviewed. A process is identified in policy for the prevention of exposing others to infection. Signage is used in the facility as needed. Sanitising hand gel is visible throughout all service areas in the facility and adequate handwashing facilities for staff, visitors and residents are available. The general practitioner is well informed of any reporting obligations for notifiable infections, outbreaks of disease and illness. There have been no infection outbreaks since the last audit. Guidelines and a pandemic plan is in place should an incident arise. Pandemic resources and food is available for any emergencies.

| Standard 3.2: Implementing the infection control programme

There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation. | FA | The infection control coordinator has a job description for this position and has attended relevant education for infection prevention and control at the DHB, inclusive of the National Health Emergency Plan update. The service utilises a contracted company which specialises in infection control for additional information and for benchmarking. The infection control nurse and the committee are overseen by the management team. External specialist advice is available through the general practitioner, diagnostic service microbiologist and the DHB infection control nurse specialists and infection control team.

The infection prevention and control committee consists of the infection control coordinator, clinical services manager and team members representing the kitchen, domestic, laundry services and care givers. All resources are available to the committee and the registered nurses can access the laboratory results. The committee meets monthly and the meeting agenda and minutes were reviewed. Other interested staff are able to attend the meetings.

The care staff and registered nurses interviewed demonstrated good knowledge in the principals of infection prevention and control. |
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| Standard 3.3: Policies and procedures

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. | FA | The infection control manual has been developed and implemented for the service using the organisation wide policies and procedures. The manual is divided into sections to cover the requirements for infection prevention and control inclusive of guidelines available, work practices, surveillance, monthly continuous quality improvement, reviews, references and appendices utilised. The goals of the infection prevention and control programme are clearly documented.

The infection control policies and procedures and external resources are accessible to staff. There are policies implemented which cover antibiotic use, methicillin resistant staphylococcus aureus (MRSA) and other antimicrobial screening, wound care management, blood and body spills management, cleaning and disinfectant are all covered adequately. Laundry, kitchen and cleaning policies and procedures are developed and implemented specifically for the relevant services provided at this facility. Standard precautions are adhered to by staff as observed during the onsite audit. Staff demonstrated safe and appropriate infection prevention and control practices. |
| Standard 3.4: Education

The organisation provides relevant education on infection control to all | FA | Infection control education is included in the orientation packs for all new employees and is included in the ongoing education programme reviewed for 2016/2017. Infection control is provided by the clinical services manager and /or the infection control coordinator at staff meetings. Outbreak management education was provided on the 11 October 2016. Hand hygiene, outbreaks, personal |

service providers, support staff, and consumers.		protective equipment usage were discussed. The outbreak trolley was discussed so that staff are aware of the location of the trolley and the contents in the event of a pandemic outbreak. External trainers are contracted as required. Study days are planned and displayed on the staff notice board. Education evidence is available and sighted on the day of the audit.

All staff interviewed, including domestic, kitchen, registered nurses and care staff, demonstrated good knowledge of infection prevention and control and the significance of handwashing. Resident education is provided as required. |
| Standard 3.5: Surveillance

Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme. | FA | The infection prevention and control surveillance that is undertaken is appropriate for this facility as shown in the infection control programme. Staff are required to take responsibility for surveillance activities as shown in the policy reviewed. An infection form is completed as soon as signs and symptoms have been identified and given to the Clinical Services Manager or the infection control coordinator. An infection control plan is developed and implemented which describes actions taken to ensure residents` safety at all times.

The infection control coordinator completes the monthly infection surveillance report. Monitoring occurs for urinary infections, eye infections, upper and lower respiratory tract infections, wound infections, multi-resistant organisms, diarrhoea, vomiting and other infections.

The monthly analysis of the infections reported includes comparison with the previous, reasons for the increase or decrease in rates of infections and the actions taken to reduce infections. Analysis includes a summary that can be fed back to staff at the staff meetings. Graphs are a diagrammatic, visual methodology which staff can relate to and these are displayed for staff on the staff notice board and a copy is retained in the infection control records. |
| Standard 2.1.1: Restraint minimisation

Services demonstrate that the use of restraint is actively minimised. | FA | There are currently seven residents using restraint and six residents using an enabler. The restraint register is current and updated. The policies and procedures have good definitions of restraints and enablers. A RN is the restraint coordinator and demonstrated good knowledge relating to restraint minimisation. Staff demonstrated sound knowledge about restraint processes including the difference between restraints and enablers. The restraint coordinator and staff described how they have minimised the use of restraint including comprehensive assessments and review and the use of equipment such as sensor mats. |
| Standard 2.2.1: Restraint approval | FA | A RN is the designated restraint coordinator. Responsibilities of the restraint coordinator and |

and processes 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.		approval committee are clearly outlined. Restraints to be used for residents are approved by the restraint approval committee prior to commencing restraint. The restraint approval committee meets three monthly. Minutes of restraint meetings confirmed this. The GP completes six-monthly review of the restraints in use. Restraint use is discussed in the quality, RN and staff meetings and was evidenced in the meeting minutes.
Standard 2.2.2: Assessment Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.	FA	Restraint assessment and application for the use of restraint forms are completed prior to commencing restraint. These were evidenced in the files of the residents using restraint. The risk factors were identified in the assessment and the purpose of the chosen restraint was documented. The desired outcomes were clearly documented in the long-term care plans. Staff demonstrated good knowledge in maintaining culturally safe practice when completing assessments for restraint use.
Standard 2.2.3: Safe Restraint Use Services use restraint safely	FA	The service actively promotes the safe use of restraint. The restraint coordinator described their expectations relating to this. There is a current and updated restraint register. The care plans ensure the resident's safety while using restraint. All interviewed staff demonstrated good knowledge about restraints and strategies to promote resident safety while using restraint. The restraint minimisation policies and procedures are in place and are accessible for all staff to read. Monitoring forms reviewed evidenced residents are viewed at the required times. There were no restraint-related injuries reported.
Standard 2.2.4: Evaluation Services evaluate all episodes of restraint.	FA	Restraint use is evaluated at least three monthly and includes the requirements set out in this standard. Each resident using restraint is also reviewed at the approval group meetings and RN and staff meetings. Care staff confirmed that their feedback was obtained by the restraint coordinator when evaluating the restraint in use.
Standard 2.2.5: Restraint Monitoring and Quality Review Services demonstrate the monitoring	FA	Monitoring and quality review is undertaken by the restraint approval group. Identified issues were discussed in these meetings as well as additional education that was required to support staff members. The internal audit programme also includes audits of restraint. The restraint minimisation

and quality review of their use of restraint.		and safe practice policies and procedures are reviewed regularly.

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.

No data to display

Specific results for criterion where a continuous improvement has been recorded

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

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

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

No data to display

End of the report.