# Oceania Care Company Limited - Otumarama Home & Hospital

## Introduction

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

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

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

You can view a full copy of the standards on the Ministry of Health’s website by clicking [here](http://www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards).

The specifics of this audit included:

**Legal entity:** Oceania Care Company Limited

**Premises audited:** Otumarama Rest Home

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

**Dates of audit:** Start date: 16 January 2017 End date: 17 January 2017

**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:** 36

# 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** |
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|  | 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 |
|  | 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

Otumarama Rest Home provides rest home and hospital level care, including physical and intellectual residential disability services, for up to 43 residents. There were 36 residents at the facility during the on-site audit. This surveillance audit was conducted against the relevant aspects of the Health and Disability Service Standards and the service’s contract with the district health board.

The audit process included the review of policies and procedures, review of resident and staff files, observations and interviews with residents, and interviews with management, staff and a general practitioner.

The previous requirements for improvement related to documentation of adverse events, identification of the needs outcomes and goals of residents, service delivery plans and evaluation of service delivery plans, have been implemented.

There is one area identified as requiring improvement relating to all performance reviews to be current.

## Consumer rights

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| 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. |

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 are accessible.

The Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights is brought to the attention of residents and their families on admission to the facility. Residents confirmed their rights are being met and staff are respectful of their needs. Observation during the on-site audit confirmed communication is appropriate.

The business and care manager is responsible for the management of complaints and a complaints register is maintained.

## Organisational management

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| Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner. |  | Some standards applicable to this service partially attained and of low risk. |

Oceania Care Company Limited is responsible for governance and its support office is responsible for executive operations. The business plan and quality and risk management systems reflect the scope, direction, goals, values and mission statement.

There is a quality and risk management system in place that supports provision of clinical care and includes systems for monitoring of service delivery. The facility’s quality and risk performance is communicated through meetings and is monitored by the management team through the business status and clinical indicator reports, including reports to the support office.

The business and care manager is supported in their role by a clinical leader. The clinical leader is responsible for the oversight and implementation of the clinical services in the facility.

There are human resource policies implemented for the management of staff. An in-service education programme ensures on-going education and training opportunities for staff. Staff training registers are maintained. New staff are required to complete orientation and induction programmes. There is a documented rationale for determining staffing levels and skill mixes to ensure safe service delivery is based on best practice.

## Continuum of service delivery

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| 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 residents’ assessments, care planning and evaluations of care are developed with resident and/or family input, within the required timeframes and coordinated to promote continuity of service delivery. The residents and family confirm their input into assessments, care planning and evaluations of care, and satisfaction with services provided at the facility.

A sampling of residents' clinical files evidenced initial assessments, initial care plans and long-term care plans are completed within the required timeframes, and include the residents’ individualised needs and required interventions. Where progress is different from expected, the service responds by initiating changes to the care plan or recording the changes on a short-term care plan.

Planned activities are appropriate to the group setting. The residents and family interviewed confirmed satisfaction with the activities programme. Individual activities are provided either within group settings or on a one-on-one basis.

There is an appropriate medicine management system in place. Staff responsible for medicine management attend medication management in-service education and have current medication competencies. The resident self-administering medicines does so according to policy.

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

## Safe and appropriate environment

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| 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. |

A current building warrant of fitness is in place. There have been no building modifications since the last audit.

## Restraint minimisation and safe practice

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| 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 documented policies and procedures for restraint minimisation and safe practice. Systems are in place to ensure assessment of residents is undertaken prior to restraint or enabler use. The staff interviews confirmed that enabler use is voluntary. There were three residents using enablers and no restraint use on days of audit.

The residents’ files reviewed demonstrated that the service focuses on de-escalation processes. The assessment, consent, care planning and review of enabler use is conducted and recorded.

## Infection prevention and control

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| 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 policies include guidelines on prevention and minimisation of infection and cross infection, and contain all requirements of the standard. Staff are familiar with infection control measures at the facility.

The infection control surveillance data confirms that the surveillance programme is appropriate for the size and complexity of the services provided.

## Summary of attainment

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

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| **Attainment Rating** | **Continuous Improvement**  **(CI)** | **Fully Attained**  **(FA)** | **Partially Attained Negligible Risk**  **(PA Negligible)** | **Partially Attained Low Risk**  **(PA Low)** | **Partially Attained Moderate Risk**  **(PA Moderate)** | **Partially Attained High Risk**  **(PA High)** | **Partially Attained Critical Risk**  **(PA Critical)** |
| **Standards** | 0 | 17 | 0 | 1 | 0 | 0 | 0 |
| **Criteria** | 0 | 43 | 0 | 1 | 0 | 0 | 0 |

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

# Attainment against the Health and Disability Services Standards

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

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

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

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

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| **Standard with desired outcome** | **Attainment Rating** | **Audit Evidence** |
| Standard 1.1.13: Complaints Management  The right of the consumer to make a complaint is understood, respected, and upheld. | FA | Oceania’s complaints policies and procedures are compliant with the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code).  Residents and family are given information regarding the complaints process on admission. There are appropriate systems in place to manage the complaints process. Complaints forms are freely available and the facility has a process to anonymously submit a complaint. Residents and their families demonstrated knowledge of how to make a complaint.  The business and care manager is responsible for the management of complaints. Complaints are monitored and managed appropriately and the complaints register is up to date.  The business and care manager stated there had been one coroner’s case since the last on-site audit. Documentation reviewed confirmed communication with the coroner and the service was waiting for the final outcome of this investigation. The investigation remains open.  No other external agencies have had complaints submitted, as stated by the business and care manager. |
| Standard 1.1.9: Communication  Service providers communicate effectively with consumers and provide an environment conducive to effective communication. | FA | Communication with residents and family occurs regularly and interviews confirmed open disclosure of information in a timely manner. Interviews with staff, management and the general practitioner (GP) confirmed that families are informed about changes in residents’ condition and/or when adverse events occur.  Interpreter services are available and can be accessed at the district health board (DHB), if required. There were no residents at the facility requiring interpreter services during the on-site audit.  Service information is provided to residents and their families as part of the information pack on admission.  Family meetings inform family members of facility activities and provide opportunities for family members to discuss issues and/or concerns they may have.  Meeting minutes of family meetings included discussions relating to satisfaction surveys, activities and shortfalls as identified through the satisfaction survey. Family members confirmed their satisfaction with the service provision at this facility. |
| 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 Oceania Care Company Limited executive team (support office) provide support to the service.  The clinical and quality manager and the national clinical and quality manager provided support to the business and care manager during the audit. The monthly business status report provides the executive management team with progress against identified indicators.  The service has a documented mission statement, values and goals. These are communicated to residents, staff and family through posters on the wall, information in booklets and in staff training.  The facility has a potential capacity for 50 residents but due to the service not using double rooms, their effective capacity is for 43 residents. Occupancy during the on-site audit was 36 residents, which included 23 residents in the hospital and 13 requiring rest home care.  The service holds additional contracts for care; including care of young people with intellectual and physical disabilities. During the on-site audit there were six people under this contract, four receiving hospital level of care and two at rest home level of care.  The business and care manager is responsible for the overall management of the service and has been in this role for 10 years. The business and care manager has previous management experience in residential care and has completed a national diploma in business (including level four & five). The business and care manager attends core study days and additional training and education specific to management exceeding eight hours annually.  The clinical care service is overseen by the clinical leader who is a registered nurse (RN) and has been in this position for approximately 18 months. |
| 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 | The service uses the Oceania Care Company Limited quality and risk management framework that is documented to guide practice and implements organisational policies and procedures to support service delivery. Policies are reviewed at the support office. Their policies are linked to the Health and Disability Sector Standards, current and applicable legislation, and evidenced-based best practice guidelines.  There are processes in place to maintain the quality and risk management system and monitor the key components of service delivery. There is documentation that includes collection, collation, and identification of trends and analysis of data. The service has four registered nurses who are able to complete interRAI assessments and all interRAI assessments are up-to-date.  Internal audits were reviewed, the internal audit schedule is implemented and results are communicated to staff. The 2016 family and resident satisfaction survey results show satisfaction with services provided. There is evidence that shortfalls from the survey were identified and corrective actions were formulated and implemented. This was also reflected in meeting minutes.  Facility meetings provide a forum of communication with all staff, residents and families. Staff report that they are kept informed of quality improvement initiatives. Residents confirmed residents’ meetings provide an opportunity for discussions with staff and management. The organisation has a risk management programme in place.  Health and safety policies and procedures are documented along with a hazard management programme. There was evidence of hazard identification forms completed when a hazard is identified. Health and safety is audited monthly with a facility health check completed by the clinical leader and quality manager. |
| 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 | Families are being informed after adverse events, confirmed in clinical records and during family and resident interviews. Accident and incident forms are reviewed and signed off by the business and care manager. Corrective action plans address areas requiring improvement and are documented. There is an open disclosure policy.  Staff confirmed during interview that they are made aware of their responsibilities for completion of adverse events and their responsibilities relating to essential notification, through: job descriptions, policies and procedures. Policy and procedures meet the terms of essential notification reporting for example: health and safety, human resources and infection control.  The previous requirement for improvement relating to some of the incidents and near misses not being documented is fully implemented. |
| Standard 1.2.7: Human Resource Management  Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation. | PA Low | Documented policies and procedures guide human resource management practice and implementation was verified. Skills and knowledge required for each position is documented in job descriptions. Job descriptions outline accountabilities, responsibilities and authorities of roles.  Staff files were reviewed for employment agreements, reference checks, police vetting and completed orientations. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice.  The in-service education programme and the core study days cover mandatory education and training in the required areas relevant to the levels of staff responsibilities and authority. The core study days are provided for RNs, health care assistants and non-clinical staff. Individual staff attendance records and attendance records for each education session were reviewed. On-going learning and education is provided. Competency assessment questionnaires are current and includes medication management, infection control and restraint. The clinical leader and four RNs have completed the required interRAI assessments training and competencies.  An appraisal schedule is in place, however, there is a requirement for improvement relating to all staff having current performance appraisals.  The service has an orientation/induction programme in place and new staff are required to complete this prior to their commencement of care to residents. Orientation for staff covers the essential components of the service provided. Signed off orientation and induction records were verified. |
| 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 in place for determining service provider levels and skill mixes in order to provide safe service delivery.  The service has two-weekly, roll-over rosters, reflected staffing levels that meet resident acuity and bed occupancy. Registered nurse cover is provided 24 hours a day, seven days a week. On call arrangements are known to staff.  Residents reported staff provide them with adequate care. Care staff reported there is adequate staff available and that they are able to get through their work. |
| 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 area, including controlled drug storage evidences 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 stock takes. The medication fridge temperatures are conducted and recorded.  All staff authorised to administer medicines have current competencies. The medication round was observed and evidenced the staff member was knowledgeable about the medicine administered and followed procedures and protocols.  Computerised medicine charts evidence residents' photo identification, legibility, as required (PRN) medication is identified for individual residents, allergies are recorded and three monthly medicine reviews are conducted. The residents' medicine charts record all medications a resident is taking (including name, dose, frequency and route to be given). There was one resident self-administering medicines at the facility and this was conducted according to policy. |
| 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, fluid and nutritional requirements of the residents is provided in line with recognised nutritional guidelines for older people as verified by the dietitian’s documented assessment of the planned menu.  In interview, the kitchen staff confirmed they were aware of residents’ individual dietary needs. The residents' dietary requirements are identified on admission, documented and communicated to kitchen staff. Reviews of residents’ dietary needs are conducted six monthly or when residents’ conditions alter. There are current copies of the residents' dietary profiles in the kitchen. The kitchen staff are informed if a resident's dietary requirements change, confirmed at staff interviews.  The residents' files demonstrated monthly monitoring of individual resident's weight. In interviews, residents stated they were satisfied with the food service, reported their individual preferences were met and adequate food and fluids were provided.  The food temperatures are recorded as are the fridge, chiller and freezer temperatures. All decanted food is dated. Kitchen staff have completed food safety training. |
| Standard 1.3.4: Assessment  Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner. | FA | At the last certification audit an area requiring improvement relating to the completion of residents’ assessments was identified. This surveillance audit evidenced this is  fully attained. The residents' needs, outcomes and goals are identified via the assessment process and recorded. The risk assessments are conducted on admission, when a resident’s condition changes and six monthly. The interRAI assessments are completed within the three weeks of residents’ admission to the facility and reviewed six monthly.  The policies and protocols are in place to ensure cooperation between service providers and to promote continuity of service delivery. The facility has processes in place to seek information from a range of sources, for example, family, GP, specialist and referrer.  The facility has appropriate resources and equipment, confirmed at staff interviews. Assessments are conducted in a safe and appropriate setting including visits from the doctor. In interviews, residents and family confirmed their involvement in assessments, care planning, review, treatment and evaluations of care. |
| Standard 1.3.5: Planning  Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. | FA | At the last certification audit an area requiring improvement relating to the long-term care plans describing the required support and interventions relating to behaviours that challenge was identified, this is now fully attained.  The residents’ care plans are individualised, integrated and current. The care plan interventions reflect the risk assessments and the level of care required. The short-term care plans are developed, when required and signed off by the RN when problems are resolved. In interviews, staff reported they receive adequate information for continuity of residents’ care. The residents have input into their care planning and review. Regular GP care is implemented, sighted in current GP progress reports and confirmed at GP interview. |
| Standard 1.3.6: Service Delivery/Interventions  Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes. | FA | The residents' care plans evidence detailed interventions based on assessed needs, desired outcomes or goals of the residents. The GP documentation and records are current. In interviews, residents and family confirmed their and their relatives’ current care and treatments meet their needs. Family communication is recorded in the residents’ files. Nursing progress notes and observation charts are maintained. In interviews, staff confirmed they are familiar with the current interventions of the resident they were allocated. |
| 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 is one activities programme for the rest home and hospital residents and includes activities for the residents under 65 years of age. There is a separate recreational area for the residents who are under the 65 years of age and specific activities are provided for these residents. Regular exercises and outings are provided for those residents able to partake. The activities programme includes input from external agencies and supports ordinary unplanned/spontaneous activities including festive occasions and celebrations. There are current, individualised activities assessments and care plans recorded in the files reviewed. The residents’ activities attendance records are maintained. Feedback is obtained from residents and family members by way of satisfaction surveys and activities audits are conducted.  In interview, the diversional therapist (DT) confirmed their involvement in the facility’s activities programme. The DT implements the activities programme four days a week. The health care assistants, volunteers and external entertainers implement residents’ activities when the DT is not at the facility. Interviews with health care assistants confirmed this.  There are two residents meetings, one for the rest home and hospital residents and one for the residents under 65 years of age. The meeting minutes evidenced residents’ involvement and consultation of the planned activities programme. |
| Standard 1.3.8: Evaluation  Consumers' service delivery plans are evaluated in a comprehensive and timely manner. | FA | At the last certification audit an area requiring improvement relating to care plan and wound care plan evaluations was identified and is now fully attained.  Timeframes in relation to care planning evaluations are documented and implemented. The residents' care plans are up to date and reviewed six monthly. There is evidence of resident, family, health care assistants, allied health staff and GP input into the care plan evaluations. In interviews, residents and families confirmed their participation in care plan evaluations and multidisciplinary reviews. Wound care plans reviewed evidenced wound management plans were current and evaluated within the required timeframes.  The residents’ progress records are entered on each shift. When resident’s progress is different than expected, the RN contacts the GP, as required. Short-term care plans were in some of the residents’ files reviewed, where required. The family are notified of any changes in a resident's condition, confirmed at family interviews.  There is recorded evidence of additional input from professionals, specialists or multidisciplinary sources, if this is required. |
| 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 at the facility. The business and care manager stated there have not been any alterations to the building since the last audit. |
| 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 control coordinator (ICC) is responsible for the surveillance programme. Monthly surveillance analysis is completed and reported at monthly clinical meetings.  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, indicators or outcomes. Infection logs are maintained for infection events. Residents’ files evidenced the residents diagnosed with an infection had short-term care plans.  In interviews, staff reported they are made aware of any infections of individual residents by way of feedback from the clinical leader, RNs, verbal handovers, short-term care plans and progress notes. This was evidenced during attendance at the staff handover and review of the residents’ files.  In interview, the ICC confirmed no outbreak has occurred at the facility since last audit. |
| Standard 2.1.1: Restraint minimisation  Services demonstrate that the use of restraint is actively minimised. | FA | The definition of restraint and enabler is congruent with the definition in the standard. The process of assessment, care planning, monitoring and evaluation of restraint and enabler use is recorded. There were three residents at the facility using enablers and no residents using restraint. The use of the enablers is documented in the residents’ files.  The approval process for enabler use is activated when a resident voluntarily requests an enabler to assist them to maintain independence and/or safety, confirmed at staff and management interviews.  In interviews with staff and in staff records there was evidence that restraint minimisation and safe practice (RMSP), enabler usage and prevention and/or de-escalation education and training was provided. |

# Specific results for criterion where corrective actions are required

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Criterion with desired outcome** | **Attainment Rating** | **Audit Evidence** | **Audit Finding** | **Corrective action required and timeframe for completion (days)** |
| Criterion 1.2.7.3  The appointment of appropriate service providers to safely meet the needs of consumers. | PA Low | Review of six staff files evidenced employment agreements, reference checks, police vetting, and completed orientations and induction records. Current copies of annual practising certificates were reviewed for all staff and contractors that require them to practice. Performance reviews were completed for four of the six reviewed staff files. | Two of the six staff files reviewed did not have current performance reviews on file. | All staff performances to be reviewed annually.  180 days |

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

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

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

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

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| No data to display |

End of the report.